FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0047696

Facility Name: AMBOY NURSING ACQUISITION

Address: 15 WEST WASSON ROAD (Number) AMBOY (City) 61310 (Zip Code)

County: LEE

Telephone Number: (815) 857-2550 **Fax #** (815) 857-4016

HFS ID Number:

Date of Initial License for Current Owners: 12/02/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: KIM WESTERKAMP **Telephone Number:** (630) 655-9104
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) BART MCCURLEY, CPA
(Firm Name & Address) SELF, MAPLES, & COPELAND, P.C. 1601 SECOND AVE EAST ONEONTA, AL 35121
(Telephone) (205) 625-3472 Fax # (205) 274-0182

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,518	4,546	524	14,588	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,518	4,546	524	14,588	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.20%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/02/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/02/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 2,248

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	136,678	7,193	55,483	199,354		199,354		199,354			1
2	Food Purchase		83,365		83,365		83,365	(129)	83,236			2
3	Housekeeping		9,234	108,720	117,954		117,954		117,954			3
4	Laundry		5,608	72,480	78,088		78,088		78,088			4
5	Heat and Other Utilities			89,576	89,576		89,576	(4,912)	84,664			5
6	Maintenance	29,342	8,839	16,086	54,267		54,267		54,267			6
7	Other (specify):*											7
8	**TOTAL General Services**	166,020	114,239	342,345	622,604		622,604	(5,041)	617,563			8
	B. Health Care and Programs											
9	Medical Director			17,200	17,200		17,200		17,200			9
10	Nursing and Medical Records	1,034,815	59,168	32,543	1,126,526		1,126,526	(30,928)	1,095,598			10
10a	Therapy			203,767	203,767		203,767		203,767			10a
11	Activities	51,412	203	1,041	52,656		52,656		52,656			11
12	Social Services	38,013		3,298	41,311		41,311		41,311			12
13	CNA Training											13
14	Program Transportation	28,628		9,033	37,661		37,661		37,661			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,152,868	59,371	266,882	1,479,121		1,479,121	(30,928)	1,448,193			16
	C. General Administration											
17	Administrative	237,956		80,160	318,116		318,116	(162,170)	155,946			17
18	Directors Fees											18
19	Professional Services			58,122	58,122		58,122	(1,670)	56,452			19
20	Dues, Fees, Subscriptions & Promotions			2,582	2,582		2,582	(2,427)	155			20
21	Clerical & General Office Expenses		111,117	47,851	158,968		158,968	(18,541)	140,427			21
22	Employee Benefits & Payroll Taxes			403,922	403,922		403,922	(2,643)	401,279			22
23	Inservice Training & Education			1,713	1,713		1,713		1,713			23
24	Travel and Seminar			1,905	1,905		1,905		1,905			24
25	Other Admin. Staff Transportation			3,332	3,332		3,332		3,332			25
26	Insurance-Prop.Liab.Malpractice			44,764	44,764		44,764		44,764			26
27	Other (specify):* UNALLOWABLE			10,500	10,500		10,500	(10,500)				27
28	**TOTAL General Administration**	237,956	111,117	654,851	1,003,924		1,003,924	(197,951)	805,973			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,556,844	284,727	1,264,078	3,105,649		3,105,649	(233,920)	2,871,729			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number AMBOY NURSING ACQUISITION #0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,419	1,419		1,419	63,930	65,349			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			95,212	95,212		95,212	(475)	94,737			32
33	Real Estate Taxes			42,000	42,000		42,000	2,736	44,736			33
34	Rent-Facility & Grounds			254,065	254,065		254,065	(254,065)				34
35	Rent-Equipment & Vehicles			17,382	17,382		17,382		17,382			35
36	Other (specify):*											36
37	**TOTAL Ownership**			410,078	410,078		410,078	(187,874)	222,204			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,463	1,463		1,463		1,463			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,744	55,744		55,744		55,744			42
43	Other (specify):* **RX DRUGS**			67,953	67,953		67,953		67,953			43
44	**TOTAL Special Cost Centers**			125,160	125,160		125,160		125,160			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,556,844	284,727	1,799,316	3,640,887		3,640,887	(421,794)	3,219,093			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,912)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(475)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,871)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,427)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (13,814)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (13,814)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

AMBOY NURSING ACQUISITION

ID# 0047696

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Unallowable	$ (10,500)	27	1
2	Overdraft Fees	(12,670)	21	2
3	Unallowable Legal Fees	(1,670)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,840)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(129)	0	0	0	0	0	0	0	0	0	0	(129)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,912)	0	0	0	0	0	0	0	0	0	0	(4,912)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,041)	0	0	0	0	0	0	0	0	0	0	(5,041)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(30,928)	0	0	0	0	0	0	0	0	0	(30,928)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(30,928)	0	0	0	0	0	0	0	0	0	(30,928)	16
	C. General Administration													
17	Administrative	0	(162,170)	0	0	0	0	0	0	0	0	0	(162,170)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,670)	0	0	0	0	0	0	0	0	0	0	(1,670)	19
20	Fees, Subscriptions & Promotions	(2,427)	0	0	0	0	0	0	0	0	0	0	(2,427)	20
21	Clerical & General Office Expenses	(18,541)	0	0	0	0	0	0	0	0	0	0	(18,541)	21
22	Employee Benefits & Payroll Taxes	0	(2,643)	0	0	0	0	0	0	0	0	0	(2,643)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(10,500)	0	0	0	0	0	0	0	0	0	0	(10,500)	27
28	**TOTAL General Administration**	(33,138)	(164,813)	0	0	0	0	0	0	0	0	0	(197,951)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,179)	(195,741)	0	0	0	0	0	0	0	0	0	(233,920)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	63,930	0	0	0	0	0	0	0	0	0	63,930	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(475)	0	0	0	0	0	0	0	0	0	0	(475)	32
33	Real Estate Taxes	0	2,736	0	0	0	0	0	0	0	0	0	2,736	33
34	Rent-Facility & Grounds	0	(254,065)	0	0	0	0	0	0	0	0	0	(254,065)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(475)	(187,399)	0	0	0	0	0	0	0	0	0	(187,874)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(38,654)	(383,140)	0	0	0	0	0	0	0	0	0	(421,794)	45

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LEWIS J BORSELLINO	80%	MORRIS HEALTHCARE & REHAB CENTER	MORRIS	PRISM HEALTHCARE GROUP		MANAGEMENT C
KIM WESTERKAMP	20%	MATTOON HEALTHCARE & REHAB CENTER	MATTOON	AMBOY REAL ESTATE HOLDING		REAL ESTATE
		DIXON HEALTHCARE & REHAB CENTER	DIXON			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 254,065	AMBOY REAL ESTATE HOLDING	0.00%	$	$ (254,065)	1
2	V	33	REAL ESTATE TAX	42,000	AMBOY REAL ESTATE HOLDING	0.00%	44,736	2,736	2
3	V	30	DEPRECIATION	1,416	AMBOY REAL ESTATE HOLDING	0.00%	65,346	63,930	3
4	V	17	MANAGEMENT FEES	237,956	PRISM HEALTHCARE GROUP	100.00%		(237,956)	4
5	V	17	MANAGEMENT SALARIES	124,800	PRISM HEALTHCARE GROUP	100.00%	200,586	75,786	5
6	V	10	CORP NURSE SALARIES	58,240	PRISM HEALTHCARE GROUP	100.00%	27,312	(30,928)	6
7	V	22	PAYROLL TAXES	15,833	PRISM HEALTHCARE GROUP	100.00%	13,190	(2,643)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 734,310			$ 351,170	$ * (383,140)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lewis Borsellino, Sr	Owner	Management	80.00	259,471	10	13.00	SALARY	$ 39,590	17	1
2	Kim Westerkamp	Owner	Management	20.00	290,662	10	13.00	SALARY	44,349	17	2
3	Julie Borsellino	Relative	Management	0.00	87,977	10	13.00	SALARY	13,423	17	3
4	Anthony Borsellino	Relative	Management	0.00	102,127	10	13.00	SALARY	15,583	17	4
5	Robert Westerkamp	Relative	Management	0.00	75,756	10	13.00	SALARY	11,649	17	5
6	Lewis Borsellino, Jr	Relative	Management	0.00	43,312	10	13.00	SALARY	6,608	17	6
7	Rita Borsellino	Relative	Management	0.00	108,445	10	13.00	SALARY	16,546	17	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 147,748		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Prism Healthcare Group
Street Address: 999 Oakmont Plaza Drive
City / State / Zip Code: Westmont, IL 60559
Phone Number: (630) 655-9104
Fax Number: (630) 655-9107

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Salaries	Days	110,197	4	$ 1,515,219	$ 1,515,219	14,588	$ 200,586	1
2	10	Corporate Nurse Salaries	Days	110,197	4	206,310	206,310	14,588	27,312	2
3	22	Payroll Taxes	Days	110,197	4	99,637		14,588	13,190	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,821,166	$ 1,721,529		$ 241,088	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank		X	Payroll Loan			$	$ 312,636			$ 25,728	1
2	Interest Income Offset										(475)	2
3												3
4												4
5												5
	Working Capital											
6	Bank Financial		X	Line of Credit				1,246,037			69,484	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,558,673			$ 94,737	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,558,673			$ 94,737	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 44,736	2
3. Under or (over) accrual (line 2 minus line 1).		$ 44,736	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 44,736	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	41,427	8
2006	42,965	9
2007	44,020	10
2008	44,736	11
2009	44,736	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBOY NURSING ACQUISITION COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0047696

CONTACT PERSON REGARDING THIS REPORT Kim Westerkamp

TELEPHONE (630) 655-9104 FAX #: (630) 655-9107

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-15-325-002	Long-Term Care Property	$ 44,736.00	$ 44,736.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,736.00	$ 44,736.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97				$ 2,043,000	$	39	$ 52,385	$ 52,385	$ 261,925	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	CALL LIGHT SYSTEM			2005	16,340		20	817	817	4,085	10
11	NURSES STATION			2005	10,120		20	506	506	2,530	11
12	DINING ROOM WINDOWS			2005	3,742		20	187	187	935	12
13	FREEZER DOOR			2005	2,185		20	109	109	546	13
14	TILE WORK			2005	3,500		20	175	175	875	14
15	SURVEY REPAIRS			2005	13,904		20	695	695	3,475	15
16	SURVEY REPAIRS			2005	2,199		20	110	110	550	16
17	SURVEY REPAIRS			2005	3,961		20	198	198	990	17
18	PHONE SYSTEM			2005	6,200		20	310	310	1,550	18
19	WATER HEATER			2005	6,490		20	325	325	1,624	19
20	WATER HEATER			2005	6,500		20	325	325	1,625	20
21	WATER SOFTENERS			2005	40,039		20	2,002	2,002	10,010	21
22	FIRE DOORS			2005	10,207		20	510	510	2,551	22
23	FIRE DOORS -WIRED			2005	1,650		20	83	83	414	23
24	RESIDENT ROOMS - PAINTED			2005	25,000		20	1,250	1,250	6,250	24
25	WANGUARD SYSTEM - ALZHEIMER UNIT			2005	24,200		20	1,210	1,210	6,050	25
26	ROOFING/GUTTERS			2005	2,500		20	125	125	625	26
27	SHOWER ROOMS/ - TILE WORK/PLUMBING			2005	16,500		20	825	825	4,125	27
28	GFI OUTLETS			2005	3,750		20	188	188	939	28
29	FIRE DOOR/KITCHEN WINDOW			2005	3,352		20	168	168	839	29
30	DRIVEWAY RESURFACED			2005	2,500		20	125	125	625	30
31	SIDEWALK			2006	3,200		20	160	160	800	31
32	SIDEWALK			2006	2,300		20	115	115	575	32
33	GUTTERS			2006	4,500		20	225	225	1,125	33
34	RESIDENT ROOMS - PAINTED			2006	21,938		20	1,097	1,097	5,485	34
35	WEST SHOWER ROOM			2006	11,033		20	552	552	1,104	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	FIRE SPRINKLER	2010	13,920		10				38
39	LIGHT FIXTURE ENCLOSURES	2010	5,920		10	197	197	197	39
40	DOOR - REHAB ROOM	2010	2,938		10	147	147	147	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,313,588	$		$ 65,120	$ 65,120	$ 322,571	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	2,715	226	226		10	226	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,715	$ 226	$ 226	$		$ 226	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,316,303	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,346	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 65,120	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 322,797	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 17,382 Description: Nursing Equipment - $16,079, Dietary Equipment - $1,303
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION

STATE OF ILLINOIS
0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	$	782	$ 84,929	$	782	$ 84,929	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		366	16,077		366	16,077	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		345	102,761		345	102,761	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	43-3	# of prescrpts				67,953		67,953	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	1,492	$ 203,767	$ 67,953	1,492	$ 271,720	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number AMBOY NURSING ACQUISITION **#** 0047696 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (774,926)	$	1
2	Cash-Patient Deposits	(1,022)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,491,558		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(31,302)		6
7	Other Prepaid Expenses	42,355		7
8	Accounts Receivable (owners or related parties)	(2,409,164)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,682,501)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	331,513		14
15	Leasehold Improvements, at Historical Cost	25,278		15
16	Equipment, at Historical Cost	1,731,462		16
17	Accumulated Depreciation (book methods)	(120,857)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,967,396	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 284,895	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 432,816	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(7,388)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,508		30
31	Accrued Taxes Payable (excluding real estate taxes)	71,625		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,289		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(143,087)		35
	Other Current Liabilities(specify):			
36	Accrued Provider Tax	27,427		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 496,190	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,558,673		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,558,673	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,054,863	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,552,388)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 502,475	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (579,600)	1
2	Restatements (describe):		2
3	**Post Closing Entries**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (579,600)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(972,788)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (972,788)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,552,388)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,454,536	1
2	Discounts and Allowances for all Levels	(176,389)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,278,147	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	337,550	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 337,550	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	(476)	15
16	Rental of Facility Space		16
17	Sale of Drugs	44,744	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(3,323)	19
20	Radiology and X-Ray	(570)	20
21	Other Medical Services		21
22	Laundry	3,705	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,080	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	475	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 475	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	182	28
28a	Other Income	7,665	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,847	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,668,099	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	622,604	31
32	Health Care	1,479,121	32
33	General Administration	1,003,924	33
	B. Capital Expense		
34	Ownership	410,078	34
	C. Ancillary Expense		
35	Special Cost Centers	69,416	35
36	Provider Participation Fee	55,744	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,640,887	40
41	**Income before Income Taxes (line 30 minus line 40)****	(972,788)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (972,788)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,003	2,099	$ 75,731	$ 36.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,402	8,034	194,631	24.23	3
4	Licensed Practical Nurses	11,906	13,379	327,192	24.46	4
5	CNAs & Orderlies	33,789	37,498	437,261	11.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,944	2,072	28,963	13.98	9
10	Activity Assistants	2,419	2,592	22,449	8.66	10
11	Social Service Workers	1,929	2,225	38,013	17.08	11
12	Dietician					12
13	Food Service Supervisor	1,622	1,856	31,256	16.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,156	10,605	105,422	9.94	15
16	Dishwashers					16
17	Maintenance Workers	1,968	2,076	29,342	14.13	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,184	2,432	60,344	24.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,156	9,599	177,612	18.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Xportation Driver	2,012	2,132	28,628	13.43	33
34	TOTAL (lines 1 - 33)	87,490	96,599	$ 1,556,844 *	$ 16.12	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	17,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	102	3,288	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	84	5,784	12-03	45
46	Other(specify)				46
47	Dental Consultant	21	1,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	207	$ 27,272		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	309	4,640	10-03	52
53	TOTAL (lines 50 - 52)	309	$ 4,640		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Suzanne Egan	Administrator	0	$ 60,344
Allocation from Mgmt	Mgmt	0	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,344

B. Administrative - Other

Description	Amount
Management Fees - Prism Healthcare Group	$ 80,160
TOTAL (agree to Schedule V, line 17, col. 3)	$ 80,160
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Data	Data Processing	$ 6,649
Health Data Sysems	Data Processing	587
Self, Maples & Copeland, PC	Accounting	35,779
Frost Rutternberg & Rothblatt	Accounting	317
Expansion Funding Partners, LLC	Legal	3,884
Clingen Callow & McLean, LLC	Legal	957
Performance Food Group	Legal	500
Ehrmann Gehlbach Badger & Lee	Legal	280
Rosenblum, Goldenhersh	Legal	7,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 56,453

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,044
Unemployment Compensation Insurance	21,460
FICA Taxes	116,814
Employee Health Insurance	234,342
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	6,682
Cafeteria Plan	580
TOTAL (agree to Schedule V, line 22, col.8)	$ 403,922

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	155
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 155

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,905
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,905

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **55,744**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.