		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: 0047696

Facility Name: AMBOY NURSING ACQUISITION

Address: 15 W WASSON RD (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: 12/05/2005

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2012 to 12/31/2012 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)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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**

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	35,502	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	35,502	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	155	471	1,761	2,387	8
9	SNF/PED					9
10	ICF	8,674	2,699		11,373	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,829	3,170	1,761	13,760	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 38.76%

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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 1,761

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	133,394	6,505	5,742	145,641		145,641		145,641			1
2	Food Purchase		96,634		96,634		96,634		96,634			2
3	Housekeeping	56,993	7,091	1,121	65,205		65,205		65,205			3
4	Laundry	41,761	1,160		42,921		42,921		42,921			4
5	Heat and Other Utilities			65,912	65,912		65,912		65,912			5
6	Maintenance	28,015	3,388	26,896	58,299		58,299	187	58,486			6
7	Other (specify):*											7
8	**TOTAL General Services**	260,163	114,778	99,671	474,612		474,612	187	474,799			8
	B. Health Care and Programs											
9	Medical Director			17,400	17,400		17,400		17,400			9
10	Nursing and Medical Records	892,014	38,030	6,531	936,575		936,575	(4,207)	932,368			10
10a	Therapy											10a
11	Activities	36,386	2,158	303	38,847		38,847		38,847			11
12	Social Services	4,149		6,110	10,259		10,259		10,259			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	932,549	40,188	30,344	1,003,081		1,003,081	(4,207)	998,874			16
	C. General Administration											
17	Administrative	73,981		250,000	323,981		323,981	(250,000)	73,981			17
18	Directors Fees											18
19	Professional Services			476,649	476,649		476,649	(326,404)	150,245			19
20	Dues, Fees, Subscriptions & Promotions			9,686	9,686		9,686	2,039	11,725			20
21	Clerical & General Office Expenses	64,031	5,096	24,959	94,086		94,086	175,648	269,734			21
22	Employee Benefits & Payroll Taxes			310,596	310,596		310,596		310,596			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,209	1,209		1,209	25,957	27,166			24
25	Other Admin. Staff Transportation			6,770	6,770		6,770		6,770			25
26	Insurance-Prop.Liab.Malpractice			52,401	52,401		52,401	5,313	57,714			26
27	Other (specify):* **Other EE Benefits**							23,653	23,653			27
28	**TOTAL General Administration**	138,012	5,096	1,132,270	1,275,378		1,275,378	(343,794)	931,584			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,330,724	160,062	1,262,285	2,753,071		2,753,071	(347,814)	2,405,257			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
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:** 01/01/2012 **Ending:** 12/31/2012

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							100,440	100,440			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							802,783	802,783			32
33	Real Estate Taxes							36,051	36,051			33
34	Rent-Facility & Grounds							15,620	15,620			34
35	Rent-Equipment & Vehicles			15,189	15,189		15,189	9,170	24,359			35
36	Other (specify):*											36
37	**TOTAL Ownership**			15,189	15,189		15,189	964,064	979,253			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,507	260,967	313,474		313,474		313,474			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,366	195,366		195,366		195,366			42
43	Other (specify):* **Non-Allowable Cos**	38,285	4,386	33,341	76,012		76,012	(76,012)				43
44	**TOTAL Special Cost Centers**	38,285	56,893	489,674	584,852		584,852	(76,012)	508,840			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,369,009	216,955	1,767,148	3,353,112		3,353,112	540,238	3,893,350			45

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

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	46,716	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				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	(7,264)	43		24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(272,193)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (232,741)		$	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 Organizatio Costs (Schedule VII)	772,979		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 772,979		36
37	**(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))**	$ 540,238		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

AMBOY NURSING ACQUISITION

ID# 0047696

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (55,792)	43	1
2	Labs - Part A	(5,277)	43	2
3	X-Rays - Part A	(3,616)	43	3
4	Offset Misc Income	(593)	21	4
5	Disallow Finance Charges	(4,063)	43	5
6	Nonallowable legal fees	(202,852)	19	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**	(272,193)		49

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Suzanne Koenig	90%	Lena Living Center	Lena	SAK Management Ser	Northfield	Mgmt. Co.
Gary Weintraub	10%	St. Anthony's Nursing & Rehab Center	Rock Island	St. Anthony's Property	Rock Island	Real Estate Entity
				Lena Propert Partners	Lena	Real Estate Entity

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. [X] 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	30	Depreciation	$	Amboy Real Estate Holdings LLC	100.00%	$ 52,385	$ 52,385	1
2	V	32	Interest		Amboy Real Estate Holdings LLC	100.00%	800,213	800,213	2
3	V	33	Real Estate Taxes		Amboy Real Estate Holdings LLC	100.00%	36,051	36,051	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 888,649	$ * 888,649	14

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

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	6	Maintenance	$	SAK Consulting Fees	100.00%	$ 187	$ 187	15
16	V	17	Administrative	250,000	SAK Consulting Fees	100.00%	0	(250,000)	16
17	V	19	Professional Services	178,538	SAK Consulting Fees	100.00%	0	(178,538)	17
18	V	19	Professional Services-Reimbursed	70,204	SAK Consulting Fees	100.00%	125,190	54,986	18
19	V	20	Dues, Fees, Subscriptions & Promotions		SAK Consulting Fees	100.00%	2,039	2,039	19
20	V	21	Clerical & General Office Expenses		SAK Consulting Fees	100.00%	176,241	176,241	20
21	V	24	Travel & Seminar		SAK Consulting Fees	100.00%	25,957	25,957	21
22	V	26	Insurance-Prop, Liab & Malpractice		SAK Consulting Fees	100.00%	5,313	5,313	22
23	V	27	Other		SAK Consulting Fees	100.00%	23,653	23,653	23
24	V	30	Depreciation		SAK Consulting Fees	100.00%	1,339	1,339	24
25	V	32	Interest		SAK Consulting Fees	100.00%	2,570	2,570	25
26	V	34	Rent - Facility & Grounds		SAK Consulting Fees	100.00%	15,620	15,620	26
27	V	35	Rent - Equipment & Vehicles		SAK Consulting Fees	100.00%	4,963	4,963	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 498,742			$ 383,072	$ * (115,670)	39

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

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic 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: SAK Management Services, LLC
Street Address: 1 Northfield Plaza, Suite 480
City / State / Zip Code: Northfield, IL 60093
Phone Number: (847) 446-8400
Fax Number: (847) 446-8432

	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	6	Maintenance	SAK Consulting Fees	1,462,931	13	$ 637	$	428,538	$ 187	1
2	19	Professional Services-Legal	SAK Consulting Fees	1,462,931	13	21,425		428,538	6,276	2
3	19	Professional Services-Other	SAK Consulting Fees	1,462,931	13	405,946		428,538	118,914	3
4	20	Dues, Fees, Subscriptions & Prom	SAK Consulting Fees	1,462,931	13	6,959		428,538	2,039	4
5	21	Clerical & General Office Expense	SAK Consulting Fees	1,462,931	13	570,158	570,158	428,538	167,017	5
6	21	Clerical & General Office Expense	SAK Consulting Fees	1,462,931	13	31,490		428,538	9,224	6
7	24	Travel & Seminar	SAK Consulting Fees	1,462,931	13	88,611		428,538	25,957	7
8	26	Insurance-Prop, Liab & Malpract	SAK Consulting Fees	1,462,931	13	18,137		428,538	5,313	8
9	27	Other - Mgmt Allocation of Benefi	SAK Consulting Fees	1,462,931	13	80,745		428,538	23,653	9
10	30	Depreciation	SAK Consulting Fees	1,462,931	13	4,571		428,538	1,339	10
11	32	Interest	SAK Consulting Fees	1,462,931	13	8,775		428,538	2,570	11
12	34	Rent - Facility & Grounds	SAK Consulting Fees	1,462,931	13	53,323		428,538	15,620	12
13	35	Rent - Equipment & Vehicles	SAK Consulting Fees	1,462,931	13	16,944		428,538	4,963	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					$ 1,307,721	$ 570,158		$ 383,072	25

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	NBT-112027139-1	X		Note Payable		09/29/11	$ 400,000	$ 275,890	09/29/2016	0.1115	$ 45,857	1
2	NBT-112020852-1	X		Note Payable		09/29/11	1,250,000	1,246,037	09/29/2016	0.0875	163,655	2
3	NBT-112020844-1	X		Note Payable		10/14/11	4,165,000	4,125,721	10/14/2016	0.1000	590,701	3
4	Northbrook B&T (Wintrust)	X		Note Payable				1,673,856				4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,815,000	$ 7,321,504			$ 800,213	9
	B. Non-Facility Related*											
10												10
11								Allocation from Mgmt Co			2,570	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,570	14
15	TOTALS (line 9+line14)						$ 5,815,000	$ 7,321,504			$ 802,783	15

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

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

** 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: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)	2011	$ 36,051	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,051	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 36,000	4
To adjust for prior year accruals		(36,000)	
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 (		$ 36,051	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year			
	2007	44,020	8
	2008	44,736	9
	2009	44,736	10
	2010	44,736	11
	2011	36,051	12

Accrual is based on prior year Real Estate Tax Bills adjusted in the current year for estimated inflation.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBOY NURSING ACQUISITION COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0047696

CONTACT PERSON REGARDING THIS REPORT Suzanne Koenig

TELEPHONE (847) 446-8400 FAX #: (847) 446 -8432

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-15-328-002	Long Term Care Property	$ 36,051.00	$ 36,051.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,051.00	$ 36,051.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 01/01/2012 Ending: 12/31/2012

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).

N/A

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(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			N/A	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		2005		$ 2,043,000	$	39	$ 52,385	$ 52,385	$ 366,695	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CALL LIGHT SYSTEM			2005	16,340		20	817	817	5,719	9
10	NURSES STATION			2005	10,120		20	506	506	3,542	10
11	DINING ROOM WINDOWS			2005	3,742		20	187	187	1,309	11
12	FREEZER DOOR			2005	2,185		20	109	109	764	12
13	TILE WORK			2005	3,500		20	175	175	1,225	13
14	SURVEY REPAIRS			2005	13,904		20	695	695	4,865	14
15	SURVEY REPAIRS			2005	2,199		20	110	110	770	15
16	SURVEY REPAIRS			2005	3,961		20	198	198	1,386	16
17	PHONE SYSTEM			2005	6,200		20	310	310	2,170	17
18	WATER HEATER			2005	6,490		20	325	325	2,274	18
19	WATER HEATER			2005	6,500		20	325	325	2,275	19
20	WATER SOFTENERS			2005	40,039		20	2,002	2,002	14,014	20
21	FIRE DOORS			2005	10,207		20	510	510	3,571	21
22	FIRE DOORS -WIRED			2005	1,650		20	83	83	580	22
23	RESIDENT ROOMS - PAINTED			2005	25,000		20	1,250	1,250	8,750	23
24	WANGUARD SYSTEM - ALZHEIMER UNIT			2005	24,200		20	1,210	1,210	8,470	24
25	ROOFING/GUTTERS			2005	2,500		20	125	125	875	25
26	SHOWER ROOMS/ - TILE WORK/PLUMBING			2005	16,500		20	825	825	5,775	26
27	GFI OUTLETS			2005	3,750		20	188	188	1,315	27
28	FIRE DOOR/KITCHEN WINDOW			2005	3,352		20	168	168	1,175	28
29	DRIVEWAY RESURFACED			2005	2,500		20	125	125	875	29
30	SIDEWALK			2006	3,200		20	160	160	1,120	30
31	SIDEWALK			2006	2,300		20	115	115	805	31
32	GUTTERS			2006	4,500		20	225	225	1,575	32
33	RESIDENT ROOMS - PAINTED			2006	21,938		20	1,097	1,097	7,679	33
34	WEST SHOWER ROOM			2006	11,033		20	552	552	2,208	34
35											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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	FIRE SPRINKLER	2010	$ 13,920	$	10	$ 1,392	$ 1,392	$ 2,784	37
38	LIGHT FIXTURE ENCLOSURES	2010	5,920		10	592	592	1,381	38
39	DOOR - REHAB ROOM	2010	2,938		10	294	294	735	39
40	HEATING & COOLING UNITS, ETC	2011	36,001		10	3,600	3,600	7,200	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)		$ 2,349,589	$		$ 70,653	$ 70,653	$ 463,881	70

**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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 324,279	$	$ 28,448	$ 28,448	10	$ 152,578	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocation from Mgmt Co			1,339	1,339			74
75	TOTALS	$ 324,279	$	$ 29,787	$ 29,787		$ 152,578	75

D. Vehicle Costs. (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	N/A			$	$	$	$		$	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)	$ 2,673,868	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 100,440	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 100,440	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 616,459	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ N/A	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: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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	Home Office Allocation				15,620			6
7	TOTAL				$ 15,620 **			7

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

9. Option to Buy: ☐ YES ☒ X NO Terms: N/A *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 24,359 Description: See Schedule 14A
(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			$ N/A	$	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.

AMBOY NURSING ACQUISITION & MANAGEMENT, LLC **Schedule 14A**
Provider #: 0047696
01/01/12 - 12/31/12

Description	Amount
Bariatric Wheel Chair	1,042
Wound Care	11,542
Oxygen Equipment	4,207
Dishwasher	2,605
Home Office Allocation	4,963
	24,359

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

It is the policy of this facility to only hire certified nurses aides.

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.

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	1,456	$ 104,862	$	1,456	$ 104,862	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		548	39,426		548	39,426	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,621	116,679		1,621	116,679	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				44,707		44,707	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					7,800		7,800	12
13	Other (specify):									13
14	TOTAL			$	3,625	$ 260,967	$ 52,507	3,625	$ 313,474	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.

Facility Name & ID Number AMBOY NURSING ACQUISITION **#** 0047696 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2012 **(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	$ 67,767	$ 67,767	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,439,025	1,439,025	3
4	Supply Inventory (priced a)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,127	27,127	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	158,784	158,784	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,692,703	$ 1,692,703	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cos		2,043,000	14
15	Leasehold Improvements, at Historical Cos	61,279	306,589	15
16	Equipment, at Historical Cos	314,453	324,279	16
17	Accumulated Depreciation (book methods)	(254,167)	(616,459)	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): Other Fixed Asset	1,421,709	1,421,709	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,543,274	$ 3,479,118	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,235,977	$ 5,171,821	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 891,733	$ 891,733	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,168	87,168	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		36,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	2,078,074	2,078,074	36
37	PreReceiver Due from Affiliated	493,202	493,202	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,550,177	$ 3,586,177	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,673,856	7,321,504	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)**	$ 1,673,856	$ 7,321,504	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,224,033	$ 10,907,681	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,988,056)	$ (5,735,860)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,235,977	$ 5,171,821	48

***(See instructions.)**

XV. Balance Sheet

Ln 9 - Other Current Assets	**Operating**	**After Consolidation**
PreRec Cash-End 12/31/2011	119,896.00	119,896.00
PreRec Funds XFR To Prism	31,820.00	31,820.00
PreReceiver Patient Refunds	7,068.00	7,068.00
Total	**158,784**	**158,784**

Ln-36 Other Current Liabilities	**Operating**	**After Consolidation**
Accrued Payroll Tax Fed EE W/H	8,304.00	8,304.00
Accrued Payroll Tax St-IL EE WH	2,320.00	2,320.00
Accrued Payroll Taxes - ER FICA	7,182.00	7,182.00
Accrued Payroll Taxes - ER FUTA	339.00	339.00
Accrued Payroll Taxes - ER SUTA	4,486.00	4,486.00
Accrued Payroll Taxes -ER ILAST	69.00	69.00
Accrued Expenses	93,272.00	93,272.00
Pre-Receiver Accrued Payroll	13,989.00	13,989.00
Pre-ReceiverAccrued Payroll Tax	169,078.00	169,078.00
Pre-Receiver Accrued Expense	271,308.00	271,308.00
Wintrust-Funding	##########	1,507,727.00
Total	**2,078,074**	**2,078,074**

Facility Name & ID Number AMBOY NURSING ACQUISITION # 0047696 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,110,419)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,110,419)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(877,637)	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 Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (877,637)	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)**	$ (1,988,056)	24 *

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,836,930	1
2	Discounts and Allowances for all Level	165,429	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,002,359	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	424,406	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 424,406	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		15
16	Rental of Facility Space		16
17	Sale of Drugs	42,138	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,294	19
20	Radiology and X-Ray	802	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 47,234	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	883	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 883	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		593	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 593	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,475,475	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	474,612	31
32	Health Care	1,003,081	32
33	General Administration	1,275,378	33
	B. Capital Expense		
34	Ownership	15,189	34
	C. Ancillary Expense		
35	Special Cost Centers	389,486	35
36	Provider Participation Fee	195,366	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,353,112	40
41	**Income before Income Taxes (line 30 minus line 40)****	(877,637)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (877,637)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,091,356	44
45	Private Pay - Net Inpatient Revenue	406,748	45
46	Medicare - Net Inpatient Revenue	427,699	46
47	Other-(specify) Insurance	76,556	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3	$ 2,002,359	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.**

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

^ **LLC Members are cash basis taxpayers**

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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	1,952	1,952	$ 61,349	$ 31.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,738	5,738	153,056	26.67	3
4	Licensed Practical Nurses	10,740	10,740	238,705	22.23	4
5	CNAs & Orderlies	31,944	31,944	403,741	12.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,263	2,263	36,386	16.08	10
11	Social Service Workers	298	298	4,149	13.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,384	11,384	133,394	11.72	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,032	28,015	13.79	17
18	Housekeepers	7,050	6,908	56,993	8.25	18
19	Laundry	2,401	2,401	41,761	17.39	19
20	Administrator	2,073	2,073	73,981	35.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,212	6,212	64,031	10.31	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 Ca MDS Nurse	1,853	1,853	35,163	18.98	32
33	Other(specify) Marketing	2,080	2,015	38,285	19.00	33
34	TOTAL (lines 1 - 33)	88,020	87,813	$ 1,369,009 *	$ 15.59	34

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

** See instructions.

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	Monthly	$ 5,742	1(3)	35
36	Medical Director	Monthly	17,400	9(3)	36
37	Medical Records Consultant	Monthly	728	10(3)	37
38	Nurse Consultant	Monthly	993	10(3)	38
39	Pharmacist Consultant	Monthly	3,160	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	165	11(3)	44
45	Social Service Consultant	Monthly	6,110	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,298		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BERNADEAN MCCOY	Administrator	0	$ 73,981
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,981

B. Administrative - Other

Description	Amount
Management Fees "Eliminated in col. 7"	$ 250,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 250,000

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C		$ 476,649
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 476,649

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,178
Unemployment Compensation Insurance	48,363
FICA Taxes	103,715
Employee Health Insurance	107,340
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 310,596

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,901
Advertising: Employee Recruitment	1,119
Health Care Worker Background Check (Indicate # of checks performed 152)	1,822
Patient Background Checks	
Employee Drug Screenings	140
Miscellaneous Licenses & Fees	1,543
Illinois Council on Long Term Care	3,048
Miscellaneous Dues & Subscriptions	113
Allocation from Mgmt Co	2,039
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,725

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,209
Allocated from Mgmt Co	25,957
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27,166

**See instructions.

Vendor	Type	Amount	
American Data	Data Processing	19,982	
Self, Maples, & Copeland, P.C.	Accounting Services	12,774	
Kay Wallin	Operations consultant	75	
Personnel Planners, Inc.	UC Consultant	1,975	
Tohtz Computer Consulting Inc	Computer	9,299	
GreenbergTraurig, LLP	Legal Fees	216,462	
SAK Management Services LLC	Legal Fees	216,082	
Total for Page 3, Line 19, Column 3		476,649	To PG21
Nonallowable Out of Period Legal		(202,852)	
Allocation from Mgmt. Co.			
Professional Services Reimbursed		(248,742)	
Legal Fees		6,276	
Consulting Fees		118,914	
Total for Page 3, Line 19, Column 8		150,245	

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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										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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 Assoc - $1,901**

(3) Did the nursing home make political contributions or payments to a politica 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 t 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 Yrs**

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

(7) Have all costs reported on this form been determined using accounting procedure 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 f 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 ove

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme during this cost report period. $ **195,366**
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 for an individual employee? **No** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie 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 f 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, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **0** Has any meal income been offset agains 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 fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste 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 o out of Schedule V? **Yes**

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