



Facility Name & ID Number AMBERWOOD NURSING & REHAB CTR

# 0047308 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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 \_\_\_\_\_**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	18,620	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)	67	13,132	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	31,752	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,686	110	2,078	3,874	8
9	SNF/PED					9
10	ICF	10,270	671	0	10,941	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,956	781	2,078	14,815	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.66%**

**D. How many bed-hold days during this year were paid by the Department?**  
0 (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

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

**I. On what date did you start providing long term care at this location?**  
Date started 06/19/06

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 06/19/06 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 19 and days of care provided 1,281

Medicare Intermediary ADMINISTAR

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number AMBERWOOD NURSING & REHAB CTR # 0047308 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	92,479	23,197	3,479	119,155		119,155	(2,660)	116,495		1
2	Food Purchase		86,227		86,227	0	86,227	(1,529)	84,698		2
3	Housekeeping	56,189	150	0	56,339		56,339	(1,983)	54,356		3
4	Laundry	28,837	5,884	1,383	36,104	0	36,104	(796)	35,308		4
5	Heat and Other Utilities			59,126	59,126		59,126	0	59,126		5
6	Maintenance	31,919	21,399	35,868	89,186		89,186	(1,080)	88,106		6
7	Other (specify):*			9,128	9,128		9,128	0	9,128		7
8	<b>TOTAL General Services</b>	<b>209,424</b>	<b>136,857</b>	<b>108,984</b>	<b>455,265</b>	<b>0</b>	<b>455,265</b>	<b>(8,048)</b>	<b>447,217</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		1,500	1,500		1,500	0	1,500		9
10	Nursing and Medical Records	783,490	60,035	86,606	930,131		930,131	44,472	974,603		10
10a	Therapy	13,562		0	13,562		13,562	0	13,562		10a
11	Activities	48,212	1,354	810	50,376		50,376	(1,806)	48,570		11
12	Social Services	15,550		2,236	17,786		17,786	0	17,786		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			97	97		97	0	97		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>860,814</b>	<b>61,389</b>	<b>91,249</b>	<b>1,013,452</b>	<b>0</b>	<b>1,013,452</b>	<b>42,666</b>	<b>1,056,118</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	49,186		0	49,186		49,186	(983)	48,203		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			40,152	40,152		40,152	18,836	58,988		19
20	Dues, Fees, Subscriptions & Promotions			14,611	14,611		14,611	(4,171)	10,440		20
21	Clerical & General Office Expenses	74,567	13,953	12,448	100,968		100,968	91,265	192,233		21
22	Employee Benefits & Payroll Taxes			175,139	175,139	0	175,139	0	175,139		22
23	Inservice Training & Education			4,048	4,048		4,048	0	4,048		23
24	Travel and Seminar			6,137	6,137		6,137	2,762	8,899		24
25	Other Admin. Staff Transportation			5,655	5,655		5,655	0	5,655		25
26	Insurance-Prop.Liab.Malpractice			70,600	70,600		70,600	1,554	72,154		26
27	Other (specify):*			71,849	71,849		71,849	(71,849)	0		27
28	<b>TOTAL General Administration</b>	<b>123,753</b>	<b>13,953</b>	<b>400,639</b>	<b>538,345</b>	<b>0</b>	<b>538,345</b>	<b>37,414</b>	<b>575,759</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,193,991</b>	<b>212,199</b>	<b>600,872</b>	<b>2,007,062</b>	<b>0</b>	<b>2,007,062</b>	<b>72,032</b>	<b>2,079,094</b>		<b>29</b>

\*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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	3,479
	REPAIRS & MAINTENANCE	0
		0
		3,479
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,383
		0
		1,383
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	21,174
	ELECTRICITY	25,008
	WATER	11,578
	CABLE TV - LOBBY	1,366
		0
		59,126
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,362
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	13,438
	ELEVATOR MAINTENANCE & REPAIR	1,559
	OUTSIDE LABOR	1,742
	EXTERMINATING SERVICE	2,113
	FIRE SERVICE	10,654
		0
		0
		0
		0
		35,868
7	<b>OTHER</b>	
	SCAVENGER	9,128
	SECURITY SERVICE	0
		0
		0
		9,128
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	1,500
		1,500

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	31,821
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	3,425
	PHARMACY CONSULTANT XVIII B 39-2	1,120
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 46-2	120
	RN CONSULTANT XVIII B 38-2	50,120
		0
		0
		86,606
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	810
		0
		810
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,236
		0
		2,236
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	97
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	23,138
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	17,014
		0
		40,152
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	110
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,157
	EMPLOYEE WANT ADS XIX F	3,025
	CONTRIBUTIONS VI 20 XIX F	75
	DUES & SUBSCRIPTIONS XIX F	843
	LICENSES & PERMITS XIX F	4,134
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	3,252
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,465
	PATIENT BACKGROUND CHECKS XIX F	550
		14,611
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	72
	PENALTIES / OVERDRAFT CHARGES VI 18	378
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	32
	TELEPHONE	11,075
	MESSENGER SERVICE	891
		0
		12,448

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	91,263
	UNEMPLOYMENT COMPENSATION XIX D	48,638
	WORKERS COMPENSATION INSURANC XIX D	10,416
	HOSPITALIZATION INSURANCE XIX D	21,133
	EMPLOYEE BENEFITS - OTHER XIX D	3,430
	EMPLOYEE PHYSICAL EXAMS XIX D	259
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		175,139
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	4,048
		4,048
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	6,137
		6,137
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	5,655
		5,655
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	70,600
		70,600
27	<b>OTHER</b>	
	BAD DEBTS VI 24	71,849
		71,849

GRAND TOTAL COLUMN 3 OTHER

600,872

AMBERWOOD NURSING & REHAB CTR  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	86,227	PATIENT MEALS	44445
LESS SALES TAX	(1,529)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	84,698	TOTAL MEALS/YEAR	44445
TOTAL PATIENT CENSUS	14,815	NET FOOD	84698
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	44445
	-----		
TOTAL PATIENT MEALS	44445	COST PER MEAL	1.91
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

AMBERWOOD NURSING &amp; REHAB CTR

#0047308

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			6,030	6,030		6,030	(3,512)	2,518			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			18,909	18,909		18,909	0	18,909			32
33	Real Estate Taxes			37,926	37,926		37,926	0	37,926			33
34	Rent-Facility & Grounds			175,000	175,000		175,000	(165,854)	9,146			34
35	Rent-Equipment & Vehicles			22,963	22,963		22,963	1,999	24,962			35
36	Other (specify):*			0	0		0	0	0			36
37	<b>TOTAL Ownership</b>			260,828	260,828	0	260,828	(167,367)	93,461			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		54,644	118,703	173,347		173,347	0	173,347			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			47,628	47,628		47,628	0	47,628			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	54,644	166,331	220,975	0	220,975	0	220,975			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,193,991	266,843	1,028,031	2,488,865	0	2,488,865	(95,335)	2,393,530			45

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

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	(4,499)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,529)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(378)	21		18
19	Entertainment	(110)	20		19
20	Contributions	(75)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(71,849)	27		24
25	Fund Raising, Advertising and Promotional	(1,157)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,252)	20		28
29	Other-Attach Schedule	(40,078)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (122,927)		\$ 0	30

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	27,592	PG 6-6C	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 27,592		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (95,335)		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	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

ID# 0047308

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	VACATION ACCRUAL	(2,660)	1	2
3	VACATION ACCRUAL	(1,983)	3	3
4	VACATION ACCRUAL	(796)	4	4
5	VACATION ACCRUAL	(1,080)	6	5
6	VACATION ACCRUAL	(29,877)	10	6
7	VACATION ACCRUAL	(1,806)	11	7
8	VACATION ACCRUAL	(1,161)	17	8
9	VACATION ACCRUAL	(715)	21	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	<b>Total</b>	(40,078)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD NURSING & REHAB CTR# 0047308

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(2,660)	0	0	0	0	0	0	0	0	0	0	(2,660)	1
2	Food Purchase	(1,529)	0	0	0	0	0	0	0	0	0	0	(1,529)	2
3	Housekeeping	(1,983)	0	0	0	0	0	0	0	0	0	0	(1,983)	3
4	Laundry	(796)	0	0	0	0	0	0	0	0	0	0	(796)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,080)	0	0	0	0	0	0	0	0	0	0	(1,080)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,048)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,048)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(29,877)	0	0	74,349	0	0	0	0	0	0	0	44,472	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,806)	0	0	0	0	0	0	0	0	0	0	(1,806)	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	<b>TOTAL Health Care and Programs</b>	<b>(31,683)</b>	<b>0</b>	<b>0</b>	<b>74,349</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>42,666</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(1,161)	0	0	0	178	0	0	0	0	0	0	(983)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	17,970	176	690	0	0	0	0	0	0	18,836	19
20	Fees, Subscriptions & Promotions	(4,594)	0	124	160	139	0	0	0	0	0	0	(4,171)	20
21	Clerical & General Office Expenses	(1,093)	0	608	1,043	90,707	0	0	0	0	0	0	91,265	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	810	966	986	0	0	0	0	0	0	2,762	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	696	487	371	0	0	0	0	0	0	1,554	26
27	Other (specify):*	(71,849)	0	0	0	0	0	0	0	0	0	0	(71,849)	27
28	<b>TOTAL General Administration</b>	<b>(78,697)</b>	<b>0</b>	<b>20,208</b>	<b>2,832</b>	<b>93,071</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37,414</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(118,428)</b>	<b>0</b>	<b>20,208</b>	<b>77,181</b>	<b>93,071</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>72,032</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD NURSING & REHAB CTR # 0047308 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(4,499)	0	113	52	822	0	0	0	0	0	0	(3,512)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(175,000)	0	429	8,717	0	0	0	0	0	0	(165,854)	34
35	Rent-Equipment & Vehicles	0	0	795	595	609	0	0	0	0	0	0	1,999	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(4,499)</b>	<b>(175,000)</b>	<b>908</b>	<b>1,076</b>	<b>10,148</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(167,367)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(122,927)</b>	<b>(175,000)</b>	<b>21,116</b>	<b>78,257</b>	<b>103,219</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(95,335)</b>	<b>45</b>

**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
ROCKTON GROUP, INC.	100	SEE ATTACHED LIST OF RELATED NURSING HOMES		AMBERWOOD HEALTH CARE CENTRE		REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 175,000	AMBERWOOD HEALTH CARE CENTRE		\$	\$	(175,000) 1
2	V							2
3	V							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		\$ 175,000			\$	\$ *	(175,000) 14

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

**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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES		\$ 17,970	\$	17,970	15
16	V	20 DUES & SUBSCRIPTIONS		"		124		124	16
17	V	21 CLERICAL		"		608		608	17
18	V	24 TRAVEL		"		810		810	18
19	V	26 INSURANCE		"		696		696	19
20	V	35 RENT - EQPT & VEH		"		795		795	20
21	V	17 ADMINISTRATIVE		"					21
22	V	30 DEPRECIATION		"		113		113	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$			\$ 21,116	\$ *	21,116	39

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

**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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10 NURSING	\$	CARLYLE NURSING ASSOCIATES, LLC		\$ 74,349	\$	74,349	15
16	V	19 PROFESSIONAL FEES		"		176		176	16
17	V	20 DUES & SUBSCRIPTIONS		"		160		160	17
18	V	21 CLERICAL		"		1,043		1,043	18
19	V	24 TRAVEL		"		966		966	19
20	V	26 INSURANCE		"		487		487	20
21	V	30 DEPRECIATION		"		52		52	21
22	V	34 RENT		"		429		429	22
23	V	35 RENT - EQPT & VEH		"		595		595	23
24	V								24
25	V								25
26	V								26
27	V								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		\$			\$ 78,257	\$ *	78,257	39

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

**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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 PROFESSIONAL FEES	\$	THE KENSINGTON GROUP, LLC		\$ 690	\$ 690	15
16	V	20 DUES & SUBSCRIPTIONS		"		139	139	16
17	V	21 CLERICAL		"		90,707	90,707	17
18	V	24 TRAVEL		"		986	986	18
19	V	26 INSURANCE		"		371	371	19
20	V	30 DEPRECIATION		"		822	822	20
21	V	34 RENT		"		8,717	8,717	21
22	V	35 RENT - EQPT & VEH		"		609	609	22
23	V	17 ADMINISTRATIVE		"		178	178	23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$ 103,219	\$ * 103,219	39

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

Facility Name & ID Number AMBERWOOD NURSING & REHAB CTR # 0047308 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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 AMBERWOOD NURSING & REHAB CTR

# 0047308

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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  NO

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

Name of Related Organization WITTINGHAM MANAGEMENT ASSOC, LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	345,796	7	\$ 419,864	\$ 14,815	\$ 17,970	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	345,796	7	2,888	14,815	124	2
3	21	CLERICAL	PATIENT DAYS	345,796	7	14,195	14,815	608	3
4	24	TRAVEL	PATIENT DAYS	345,796	7	18,932	14,815	810	4
5	26	INSURANCE	PATIENT DAYS	345,796	7	16,262	14,815	696	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	345,796	7	18,569	14,815	795	6
7	17	ADMINISTRATIVE	PATIENT DAYS	345,796	7			0	7
8	30	DEPRECIATION	PATIENT DAYS	345,796	7	2,647	14,815	113	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					\$ 493,357	\$	\$ 21,116	25

Facility Name & ID Number AMBERWOOD NURSING & REHAB CTR

# 0047308

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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  NO

Name of Related Organization CARLYLE NURSING ASSOC. LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVEL IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT COST	1	\$ 74,349	\$ 74,349	1	\$ 74,349	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	6,221	14,815	176	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	5,639	14,815	160	3
4	21	CLERICAL	PATIENT DAYS	522,604	11	36,838	14,815	1,043	4
5	24	TRAVEL	PATIENT DAYS	522,604	11	34,123	14,815	966	5
6	26	INSURANCE	PATIENT DAYS	522,604	11	17,224	14,815	487	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	11	1,834	14,815	52	7
8	34	RENT	PATIENT DAYS	522,604	11	15,145	14,815	429	8
9	35	RENT & EQPT & VEH	PATIENT DAYS	522,604	11	21,023	14,815	595	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				\$ 212,396	\$ 74,349		\$ 78,257	25

Facility Name & ID Number AMBERWOOD NURSING & REHAB CTR

# 0047308

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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  NO

Name of Related Organization THE KENSINGTON GROUP, LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	\$ 24,352	\$ 14,815	\$ 690	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	4,910	14,815	139	2
3	21	CLERICAL	PATIENT DAYS	522,604	11	162,920	14,815	4,619	3
4	24	TRAVEL	PATIENT DAYS	522,604	11	34,777	14,815	986	4
5	26	INSURANCE	PATIENT DAYS	522,604	11	13,097	14,815	371	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	11	28,982	14,815	822	6
7	34	RENT	PATIENT DAYS	522,604	11	307,494	14,815	8,717	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	522,604	11	21,468	14,815	609	8
9	17	ADMINISTRATIVE	DIRECT COST	1	1	178	178	178	9
10	21	CLERICAL	DIRECT COST	1	1	86,088	86,088	86,088	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					\$ 684,266	\$ 86,266	\$ 103,219	25

**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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	ALBANK		X	WORKING CAPITAL	DEMAND	12/06	1,200,000	1,200,000	DEMAND	PRIME+	18,684									
7	CHESTERFIELD	X		WORKING CAPITAL	DEMAND	12/06	148,000	148,000	DEMAND	VARIES	225									
8																				
9	TOTAL Facility Related						\$ 1,348,000	\$ 1,348,000			\$ 18,909									
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC		X	LATE FEES																
11																				
12																				
13																				
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0									
15	TOTALS (line 9+line14)						\$ 1,348,000	\$ 1,348,000			\$ 18,909									

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	\$	<b>0</b>	<b>1</b>
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.)	\$	<b>0</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>0</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>37,926</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>37,926</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	_____	<b>8</b>
	2002	_____	<b>9</b>
	2003	_____	<b>10</b>
	2004	_____	<b>11</b>
	2005	<b>0</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME AMBERWOOD NURSING & REHAB CTR COUNTY WINNEBAGO COUNTY

FACILITY IDPH LICENSE NUMBER 0047308

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	<u>NURSING HOME</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>0.00</u>	\$ <u>0.00</u>

**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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 39,171 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (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?  (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  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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>391,714</u>	<u>1994</u>	<u>\$ 160,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>391,714</b>		<b>\$ 160,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	FLUSH STEEL DOOR WITH MISCO WIRE GLASS		2006	2,010	21	27.5	21		21
10	METAL DOOR WITH FULL MORTISE HINGE		2006	1,784	14	27.5	14		14
11	WHEEL CHAIR RAMPS		2006	2,650	20	27.5	20		20
12	DRYWALL FRAME; INSULATED METAL DOOR		2006	1,070	8	27.5	8		8
13	REMOVE & REPLACE 7 SECTIONS OF CONCRETE SIDEWALK		2006	1,950	9	27.5	9		9
14	REMOVE OLD & INSTALL NEW ALUMINUM SIGN		2006	4,135	6	27.5	6		6
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			13,599	78		78	0	78

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

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	\$	\$	\$	\$ 0		\$	71
72	Current Year Purchases	75,166	5,952	1,453	(4,499)	3-10 YRS	1,453	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY ALLOC.		987	987	0			74
75	TOTALS	\$ 75,166	\$ 6,939	\$ 2,440	\$ (4,499)		\$ 1,453	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				\$	\$	\$	\$ 0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 248,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,017	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,518	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,499)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,531	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.

**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: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

16. Rental Amount for movable equipment: \$ 20,515 Description: SEE SCHEDULE ATTACHED

(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	ADMINISTRATIVE	2006 TOYOTA CAMRY	\$ 489.67	\$ 2,448	17
18					18
19					19
20					20
21	TOTAL		\$ 489.67	\$ 2,448	21

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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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)	
<b>TOTAL TRAINED</b>	

- (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.

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

	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	39-3	hrs	\$		\$ 63,107	\$		\$ 63,107	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,554			3,554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			52,042			52,042	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 prescripts				45,318		45,318	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES, XRAY, LAB. Other (specify): <b>RENTALS, I.V. TPY</b>	39-2					9,326		9,326	13
14	<b>TOTAL</b>			\$		\$ 118,703	\$ 54,644		\$ 173,347	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 &amp; ID Number AMBERWOOD NURSING &amp; REHAB CTR

# 0047308

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 47,119	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,106,983		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,919		6
7	Other Prepaid Expenses	2,601		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,226,622	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,600		15
16	Equipment, at Historical Cost	75,164		16
17	Accumulated Depreciation (book methods)	(6,030)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 82,734	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,309,356	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 592,421	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,227		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,709		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,511		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,926		32
33	Accrued Interest Payable	800		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 749,594	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,348,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,348,000	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,097,594	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (788,238)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,309,356	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>0</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>0</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(788,238)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (788,238)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (788,238)	<b>24</b> *

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

**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**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,860,202	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,860,202	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	8
	<b>C. Other Operating Revenue</b>		
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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 0	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>NET VENDING COMMISSIONS</b>	145	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 145	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,860,347	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	455,265	31
32	Health Care	1,013,452	32
33	General Administration	538,345	33
	<b>B. Capital Expense</b>		
34	Ownership	260,828	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	173,347	35
36	Provider Participation Fee	47,628	36
	<b>D. Other Expenses (specify):</b>		
37	<b>PRIOR OWNERS EXPENSES PAID</b>	159,720	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,648,585	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(788,238)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (788,238)	43

\* 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.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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.

Facility Name & ID Number **AMBERWOOD NURSING & REHAB CTR**

# **0047308**

Report Period Beginning: **01/01/2006**

Ending:

**12/31/2006**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,116	1,151	\$ 61,533	\$ 53.46	1
2	Assistant Director of Nursing	387	399	11,291	28.30	2
3	Registered Nurses	1,990	2,038	50,306	24.68	3
4	Licensed Practical Nurses	12,318	12,716	281,486	22.14	4
5	CNAs & Orderlies	39,247	40,455	378,874	9.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,266	1,309	13,562	10.36	8
9	Activity Director	1,083	1,127	16,903	15.00	9
10	Activity Assistants	4,711	4,795	31,309	6.53	10
11	Social Service Workers	1,048	1,127	15,550	13.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,042	1,127	18,257	16.20	14
15	Cook Helpers/Assistants	9,692	9,941	74,222	7.47	15
16	Dishwashers					16
17	Maintenance Workers	3,081	3,168	31,919	10.08	17
18	Housekeepers	7,285	7,531	56,189	7.46	18
19	Laundry	4,188	4,349	28,837	6.63	19
20	Administrator	1,380	1,480	49,186	33.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,255	6,454	74,567	11.55	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)					33
34	TOTAL (lines 1 - 33)	96,089	99,167	\$ 1,193,991 *	\$ 12.04	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	71	\$ 3,479	1-3	35
36	Medical Director	36	1,500	9-3	36
37	Medical Records Consultant	50	3,425	10-3	37
38	Nurse Consultant	1,151	50,120	10-3	38
39	Pharmacist Consultant	56	1,120	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	12	810	11-3	44
45	Social Service Consultant	35	2,236	12-3	45
46	Other(specify) <b>PSYCHIATRIC</b>	2	120	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,412	\$ 62,810		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	85	\$ 3,730	10-3	50
51	Licensed Practical Nurses	738	27,951	10-3	51
52	Certified Nurse Assistants/Aides	7	140	10-3	52
53	TOTAL (lines 50 - 52)	830	\$ 31,821		53





Facility Name &amp; ID Number AMBERWOOD NURSING &amp; REHAB CTR

# 0047308

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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? NO  
If YES, give association name and amount. \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,721 Line 10-2
- (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. \_\_\_\_\_
- (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. \$ 47,628  
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.
- (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? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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 \$2500, 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