

Facility Name & ID Number AMBERWOOD NURSING & REHAB

0047308 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)	67	24,455	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	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	2,690	349	6,766	9,805	8
9	SNF/PED					9
10	ICF	19,276	2,505		21,781	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,966	2,854	6,766	31,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.42%

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 87 and days of care provided 4,171

Medicare Intermediary NATIONAL GOV'T SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number AMBERWOOD NURSING & REHAB # 0047308 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	197,423	44,669	8,307	250,399		250,399	(506)	249,893		1
2	Food Purchase		188,144		188,144		188,144	(2,486)	185,658		2
3	Housekeeping	131,566	8,681		140,247		140,247	(227)	140,020		3
4	Laundry	56,811	22,682		79,493		79,493	292	79,785		4
5	Heat and Other Utilities			131,420	131,420		131,420		131,420		5
6	Maintenance	63,530	32,939	64,879	161,348		161,348	(307)	161,041		6
7	Other (specify):*			19,974	19,974		19,974		19,974		7
8	TOTAL General Services	449,330	297,115	224,580	971,025		971,025	(3,234)	967,791		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,841,446	115,798	21,445	1,978,689		1,978,689	67,275	2,045,964		10
10a	Therapy	48,699			48,699		48,699		48,699		10a
11	Activities	102,977	5,184	5,100	113,261		113,261	(1,084)	112,177		11
12	Social Services	28,610		4,368	32,978		32,978		32,978		12
13	CNA Training										13
14	Program Transportation			583	583		583		583		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,021,732	120,982	41,096	2,183,810		2,183,810	66,191	2,250,001		16
	C. General Administration										
17	Administrative	99,709			99,709		99,709	627	100,336		17
18	Directors Fees										18
19	Professional Services			105,298	105,298		105,298	24,014	129,312		19
20	Dues, Fees, Subscriptions & Promotions			28,007	28,007		28,007	(21,375)	6,632		20
21	Clerical & General Office Expenses	124,260	24,396	315,018	463,674		463,674	(181,205)	282,469		21
22	Employee Benefits & Payroll Taxes			450,960	450,960		450,960		450,960		22
23	Inservice Training & Education			3,204	3,204		3,204		3,204		23
24	Travel and Seminar			2,042	2,042		2,042	6,488	8,530		24
25	Other Admin. Staff Transportation			1,258	1,258		1,258		1,258		25
26	Insurance-Prop.Liab.Malpractice			134,809	134,809		134,809	3,896	138,705		26
27	Other (specify):*			12,057	12,057		12,057	(12,057)			27
28	TOTAL General Administration	223,969	24,396	1,052,653	1,301,018		1,301,018	(179,612)	1,121,406		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,695,031	442,493	1,318,329	4,455,853		4,455,853	(116,655)	4,339,198		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,307
	REPAIRS & MAINTENANCE	0
		0
		8,307
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	49,701
	ELECTRICITY	61,199
	WATER	18,062
	CABLE TV - LOBBY	2,458
		0
		131,420
6	MAINTENANCE	
	GROUNDS MAINTENANCE	10,182
	PAINTING & DECORATING	6,991
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	34,001
	ELEVATOR MAINTENANCE & REPAIR	6,022
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,900
	FIRE SERVICE	3,783
		0
		0
		0
		0
		64,879
7	OTHER	
	SCAVENGER	19,974
	SECURITY SERVICE	0
		0
		0
		19,974
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,600
		9,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	525
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	5,379
	PHARMACY CONSULTANT XVIII B 39-2	3,413
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 47-2	9,900
	RN CONSULTANT XVIII B 38-2	2,228
		0
		0
		21,445
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	5,100
		0
		5,100
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	3,948
	SOCIAL WORKER XVIII B 45-2	420
		0
		4,368
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	583
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	34,805
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	70,493
		0
		105,298
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	21,608
	EMPLOYEE WANT ADS XIX F	650
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	195
	LICENSES & PERMITS XIX F	1,563
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	313
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,708
	PATIENT BACKGROUND CHECKS XIX F	1,920
		28,007
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	85
	EQUIPMENT REPAIR & MAINTENANCE	481
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	291,599
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,481
	MESSENGER SERVICE	2,372
		0
		315,018

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	203,838
	UNEMPLOYMENT COMPENSATION XIX D	127,313
	WORKERS COMPENSATION INSURANC XIX D	75,286
	HOSPITALIZATION INSURANCE XIX D	42,149
	EMPLOYEE BENEFITS - OTHER XIX D	2,289
	EMPLOYEE PHYSICAL EXAMS XIX D	85
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		450,960
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,204
		3,204
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	2,042
		2,042
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,258
		1,258
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	134,809
		134,809
27	OTHER	
	BAD DEBTS VI 24	12,057
		12,057

GRAND TOTAL COLUMN 3 OTHER

1,318,329

**AMBERWOOD NURSING & REHAB
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	188,144
LESS SALES TAX	<u>(2,486)</u>
NET FOOD	185,658

TOTAL PATIENT CENSUS	31,586
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	94,758

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	94,758
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	94,758

NET FOOD	185,658
DIVIDE TOTAL MEALS/YEAR	<u>94,758</u>

COST PER MEAL	1.96
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

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

#0047308

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			35,707	35,707		35,707	(20,455)	15,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			86,505	86,505		86,505		86,505			32
33	Real Estate Taxes			72,153	72,153		72,153		72,153			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(276,199)	23,801			34
35	Rent-Equipment & Vehicles			15,833	15,833		15,833	4,969	20,802			35
36	Other (specify):* STORAGE			1,243	1,243		1,243		1,243			36
37	TOTAL Ownership			511,441	511,441		511,441	(291,685)	219,756			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		180,708	285,363	466,071		466,071		466,071			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,695	88,695		88,695		88,695			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		180,708	374,058	554,766		554,766		554,766			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,695,031	623,201	2,203,828	5,522,060		5,522,060	(408,340)	5,113,720			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(23,145)	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	(2,486)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(291,599)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,027)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,057)	27		24
25	Fund Raising, Advertising and Promotional	(21,608)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(313)	20		28
29	Other-Attach Schedule	(10,777)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (363,062)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,278)	PG 6-6C	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,278)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (408,340)		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
		Yes	No	Amount	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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

AMBERWOOD NURSING & REHAB

ID# 0047308

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	VACATION ACCRUAL	(506)	1	2
3	VACATION ACCRUAL	(227)	3	3
4	VACATION ACCRUAL	292	4	4
5	VACATION ACCRUAL	(307)	6	5
6	VACATION ACCRUAL	(3,316)	10	6
7	VACATION ACCRUAL	(1,084)	11	7
8	VACATION ACCRUAL	627	17	8
9	VACATION ACCRUAL	(1,353)	21	9
10	MEDICARE A CONSULTANT	(2,600)	19	10
11	MEDICARE B BILLING	(13)	19	11
12	MARKETING CONSULTANT	(2,290)	19	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	(10,777)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD NURSING & REHAB# 0047308

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(506)	0	0	0	0	0	0	0	0	0	0	(506)	1
2	Food Purchase	(2,486)	0	0	0	0	0	0	0	0	0	0	(2,486)	2
3	Housekeeping	(227)	0	0	0	0	0	0	0	0	0	0	(227)	3
4	Laundry	292	0	0	0	0	0	0	0	0	0	0	292	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(307)	0	0	0	0	0	0	0	0	0	0	(307)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,234)	0	0	0	0	0	0	0	0	0	0	(3,234)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,316)	0	0	70,591	0	0	0	0	0	0	0	67,275	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,084)	0	0	0	0	0	0	0	0	0	0	(1,084)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,400)	0	0	70,591	0	0	0	0	0	0	0	66,191	16
	C. General Administration													
17	Administrative	627	0	0	0	0	0	0	0	0	0	0	627	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,930)	0	27,071	461	2,412	0	0	0	0	0	0	24,014	19
20	Fees, Subscriptions & Promotions	(21,971)	0	249	68	279	0	0	0	0	0	0	(21,375)	20
21	Clerical & General Office Expenses	(292,952)	0	5,648	773	105,326	0	0	0	0	0	0	(181,205)	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	2,576	1,852	2,060	0	0	0	0	0	0	6,488	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	1,052	1,221	1,623	0	0	0	0	0	0	3,896	26
27	Other (specify):*	(12,057)	0	0	0	0	0	0	0	0	0	0	(12,057)	27
28	TOTAL General Administration	(332,283)	0	36,596	4,375	111,700	0	0	0	0	0	0	(179,612)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(339,917)	0	36,596	74,966	111,700	0	0	0	0	0	0	(116,655)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD NURSING & REHAB

0047308

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(23,145)	0	261	117	2,312	0	0	0	0	0	0	(20,455)	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	(300,000)	0	942	22,859	0	0	0	0	0	0	(276,199)	34
35	Rent-Equipment & Vehicles	0	0	1,679	1,903	1,387	0	0	0	0	0	0	4,969	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,145)	(300,000)	1,940	2,962	26,558	0	0	0	0	0	0	(291,685)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(363,062)	(300,000)	38,536	77,928	138,258	0	0	0	0	0	0	(408,340)	45

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	\$ 300,000	AMBERWOOD HEALTH CARE CENTRE		\$	\$	(300,000) 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		\$ 300,000			\$	\$ *	(300,000) 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		\$ 27,071	\$	27,071	15
16	V	20 DUES & SUBSCRIPTIONS		"		249		249	16
17	V	21 CLERICAL		"		5,648		5,648	17
18	V	24 TRAVEL		"		2,576		2,576	18
19	V	26 INSURANCE		"		1,052		1,052	19
20	V	35 RENT - EQPT & VEH		"		1,679		1,679	20
21	V								21
22	V	30 DEPRECIATION		"		261		261	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	Total		\$			\$ 38,536	\$ *	38,536	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		\$ 70,591	\$	70,591	15
16	V	19 PROFESSIONAL FEES		"		461		461	16
17	V	20 DUES & SUBSCRIPTIONS		"		68		68	17
18	V	21 CLERICAL		"		773		773	18
19	V	24 TRAVEL		"		1,852		1,852	19
20	V	26 INSURANCE		"		1,221		1,221	20
21	V	30 DEPRECIATION		"		117		117	21
22	V	34 RENT		"		942		942	22
23	V	35 RENT - EQPT & VEH		"		1,903		1,903	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		\$			\$ 77,928	\$ *	77,928	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		\$ 2,412	\$	2,412	15
16	V	20 DUES & SUBSCRIPTIONS		" "		279		279	16
17	V	21 CLERICAL		" "		105,326		105,326	17
18	V	24 TRAVEL		" "		2,060		2,060	18
19	V	26 INSURANCE		" "		1,623		1,623	19
20	V	30 DEPRECIATION		" "		2,312		2,312	20
21	V	34 RENT		" "		22,859		22,859	21
22	V	35 RENT - EQPT & VEH		" "		1,387		1,387	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	Total		\$			\$ 138,258	\$ *	138,258	39

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

Facility Name & ID Number AMBERWOOD NURSING & REHAB # 0047308 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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**

0047308

Report Period Beginning:

01/01/2007

Ending: **2/31/2007**

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 WITTINGHAM MANAGEMENT ASSOC. LTD
 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	368,840	7	\$ 316,248	\$ 31,586	\$ 27,071	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	368,840	7	2,914	31,586	249	2
3	21	CLERICAL	PATIENT DAYS	368,840	7	65,982	31,586	5,648	3
4	24	TRAVEL	PATIENT DAYS	368,840	7	30,090	31,586	2,576	4
5	26	INSURANCE	PATIENT DAYS	368,840	7	12,294	31,586	1,052	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	368,840	7	19,611	31,586	1,679	6
7									7
8	30	DEPRECIATION	PATIENT DAYS	368,840	7	3,051	31,586	261	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					\$ 450,190	\$	\$ 38,536	25

Facility Name & ID Number AMBERWOOD NURSING & REHAB

0047308

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 CARLYLE NURSING 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	10	NURSING	DIRECT COST	1	\$ 70,591	\$ 70,591	1	\$ 70,591	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	8,078	31,586	461	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	1,197	31,586	68	3
4	21	CLERICAL	PATIENT DAYS	553,355	11	13,541	31,586	773	4
5	24	TRAVEL	PATIENT DAYS	553,355	11	32,426	31,586	1,852	5
6	26	INSURANCE	PATIENT DAYS	553,355	11	21,389	31,586	1,221	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	11	2,056	31,586	117	7
8	34	RENT	PATIENT DAYS	553,355	11	16,500	31,586	942	8
9	35	RENT & EQPT & VEH	PATIENT DAYS	553,355	11	33,327	31,586	1,903	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				\$ 199,105	\$ 70,591		\$ 77,928	25

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

0047308

Report Period Beginning:

01/01/2007

Ending: **2/31/2007**

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 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	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	\$ 42,255	\$ 31,586	\$ 2,412	1	
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	31,586	279	2	
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	31,586	11,638	3	
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	31,586	2,060	4	
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	31,586	1,623	5	
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	31,586	2,312	6	
7	34	RENT	PATIENT DAYS	553,355	11	400,473	31,586	22,859	7	
8	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	11	24,297	31,586	1,387	8	
9									9	
10	21	CLERICAL	DIRECT COST	1	1	93,688	93,688	1	93,688	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					\$ 874,509	\$ 93,688	\$ 138,258	25	

Facility Name & ID Number

AMBERWOOD NURSING & REHAB

0047308

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	ALBANK		X	WORKING CAPITAL	DEMAND	12/06	1,200,000	1,250,000	DEMAND	PRIME +	70,359	6						
7	CHESTERFIELD	X		WORKING CAPITAL	DEMAND	12/06	148,000	1,588,219	DEMAND	VARIES	15,413	7						
8	WITTINGHAM	X		WORKING CAPITAL	DEMAND	12/07	593,000	593,000			733	8						
9	TOTAL Facility Related						\$ 1,941,000	\$ 3,431,219			\$ 86,505	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,941,000	\$ 3,431,219			\$ 86,505	15						

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 2006 report.	\$	37,926	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.)	\$	37,926	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	72,153	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	72,153	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	8
	2003	9
	2004	10
	2005	11
	2006	37,926

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2006 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBERWOOD NURSING & REHAB 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 2006 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 2006.

	(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>11-11-354-001</u>	<u>NURSING HOME</u>	\$ <u>71,099.30</u>	\$ <u>37,926.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>71,099.30</u>	\$ <u>37,926.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

	1	2	3	4	
A. Land.	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	TOTALS	391,714		\$ 160,000	3

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									
Improvement Type**									
9	FLUSH STEEL DOOR WITH MISCO WIRE GLASS		2006	2,010	73	27.5	73		94
10	METAL DOOR WITH FULL MORTISE HINGE		2006	1,784	64	27.5	64		78
11	WHEEL CHAIR RAMPS		2006	2,650	96	27.5	96		116
12	DRYWALL FRAME; INSULATED METAL DOOR		2006	1,070	39	27.5	39		47
13	REMOVE & REPLACE 7 SECTIONS OF CONCRETE SIDEWALK		2006	1,950	71	27.5	71		80
14	REMOVE OLD & INSTALL NEW ALUMINUM SIGNS		2006	4,135	151	27.5	151		157
15	DOOR PROTECTIVE DEVICES ON 2 PASSENGER ELEVATORS		2007	2,300	77	27.5	77		77
16	PANELS, VALENCES & BORDERS - 2ND FLOOR		2007	11,346	756	10	756		756
17	TILES & GROUT - 2ND FLOOR		2007	8,622	131	27.5	131		131
18	TOILETS - 2ND FLOOR		2007	646	10	27.5	10		10
19	2 BARRIER FREE SHOWERS		2007	3,998	61	27.5	61		61
20	TILES - 2ND FLOOR		2007	939	9	27.5	9		9
21	BREAKING OUT CONCRETE AND INSTALL NEW DRAIN		2007	734	7	27.5	7		7
22	CUSTOM FORM OVC FRAME GUARDS - 2ND FLOOR		2007	3,845	35	27.5	35		35
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	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			46,029		1,580		1,580	1,658

**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	\$ 75,166	\$ 27,268	\$ 9,267	\$ (18,001)	3-10 YRS	\$ 10,720	71
72	Current Year Purchases	\$ 34,298	\$ 6,859	\$ 1,715	\$ (5,144)	3-10 YRS	\$ 1,715	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		\$ 2,690	\$ 2,690				74
75	TOTALS	\$ 109,464	\$ 36,817	\$ 13,672	\$ (23,145)		\$ 12,435	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 315,493	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,397	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,252	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,145)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,093	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: N/A RELATED PARTY

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?

YES NO

16. Rental Amount for movable equipment: \$ 9,957 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 TOYOTO CAMRY	\$ 489.67	\$ 5,876	17
18					18
19					19
20					20
21	TOTAL		\$ 489.67	\$ 5,876	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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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	\$		\$ 142,379	\$		\$ 142,379	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,643			8,643	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			134,341			134,341	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				119,513		119,513	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): RENTALS, I.V. TPY	39-2					61,195		61,195	13
14	TOTAL			\$		\$ 285,363	\$ 180,708		\$ 466,071	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 AMBERWOOD NURSING & REHAB

0047308

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 79,403	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,989,695		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,555		6
7	Other Prepaid Expenses	9,338		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,169,991	\$	10
	B. Long-Term Assets			
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	46,030		15
16	Equipment, at Historical Cost	109,462		16
17	Accumulated Depreciation (book methods)	(41,737)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 113,755	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,283,746	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,316,554	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,662		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,464		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,696		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,153		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,523,529	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,536,219		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)	\$ 3,536,219	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,059,748	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,776,002)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,283,746	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (788,238)	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (788,241)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(987,761)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (987,761)	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)	\$ (1,776,002)	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,534,222	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,534,222	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	44	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 44	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	33	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,534,299	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	971,025	31
32	Health Care	2,183,810	32
33	General Administration	1,301,018	33
B. Capital Expense			
34	Ownership	511,441	34
C. Ancillary Expense			
35	Special Cost Centers	466,071	35
36	Provider Participation Fee	88,695	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38	PRIOR OWNERS EXPENSES PAID		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,522,060	40
41	Income before Income Taxes (line 30 minus line 40)**	(987,761)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (987,761)	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**

0047308

Report Period Beginning: **01/01/2007**

Ending: **12/31/2007**

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	1,977	2,090	\$ 118,087	\$ 56.50	1
2	Assistant Director of Nursing	2,013	2,086	58,388	27.99	2
3	Registered Nurses	7,749	8,318	211,792	25.46	3
4	Licensed Practical Nurses	25,248	27,094	615,453	22.72	4
5	CNAs & Orderlies	74,849	80,364	764,040	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,476	4,818	48,699	10.11	8
9	Activity Director	1,849	1,981	31,299	15.80	9
10	Activity Assistants	9,544	10,082	71,678	7.11	10
11	Social Service Workers	1,685	1,852	28,610	15.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,028	2,086	33,792	16.20	14
15	Cook Helpers/Assistants	20,315	21,520	163,631	7.60	15
16	Dishwashers					16
17	Maintenance Workers	5,731	6,097	63,530	10.42	17
18	Housekeepers	14,909	16,110	131,566	8.17	18
19	Laundry	7,484	8,000	56,811	7.10	19
20	Administrator	2,071	2,249	99,709	44.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,407	10,230	124,260	12.15	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	2,945	3,254	73,686	22.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,280	208,231	\$ 2,695,031 *	\$ 12.94	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	118	\$ 8,307	1-3	35
36	Medical Director	56	9,600	9-3	36
37	Medical Records Consultant	50	5,379	10-3	37
38	Nurse Consultant	34	2,228	10-3	38
39	Pharmacist Consultant	96	3,413	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	39	5,100	11-3	44
45	Social Service Consultant	87	4,368	12-3	45
46	Other(specify) PSYCHO SOCIAL	9	525	10-3	46
47	PSYCHIATRIC	72	9,900	10-3	47
48					48
49	TOTAL (lines 35 - 48)	561	\$ 48,820		49

C. CONTRACT NURSES

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

Facility Name & ID Number AMBERWOOD NURSING & REHAB

0047308

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. \$ 2,548 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. \$ 88,695
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees