

		FOR BHF USE					

LL1

2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

I. IDPH License ID Number: 0048504

Facility Name: AMBERWOOD CARE CENTER

Address: 2313 NORTH ROCKTON AVENUE ROCKFORD 61103
Number City Zip Code

County: WINNEBAGO COUNTY

Telephone Number: (815) 964-4644 Fax # (847) 965-7722

HFS ID Number: 20-5054350

Date of Initial License for Current Owners: 06/19/2006

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2008 to 12/31/2008 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>SHAEL BELLOWS</u>	
	(Title) <u>MANAGEMENT CONSULTANT</u>	
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____
	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	
	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	

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

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	34,770	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)	67	24,522	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,292	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	9,154	874	4,965	14,993	8
9	SNF/PED					9
10	ICF	14,109	1,347	2,317	17,773	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,263	2,221	7,282	32,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.26%

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 3,462

Medicare Intermediary NATIONAL GOV'T SERVICES

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number

AMBERWOOD CARE CENTER

0048504

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclassification	Reclassified Total	Adjustments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	206,582	34,804	9,810	251,196		251,196	(1,875)	249,321		1
2	Food Purchase		206,141		206,141		206,141	(4,975)	201,166		2
3	Housekeeping	122,053	24,576		146,629		146,629	477	147,106		3
4	Laundry	34,390	12,575	753	47,718		47,718	(124)	47,594		4
5	Heat and Other Utilities			147,762	147,762		147,762		147,762		5
6	Maintenance	71,185	44,065	54,233	169,483		169,483	(424)	169,059		6
7	Other (specify):*			20,897	20,897		20,897		20,897		7
8	TOTAL General Services	434,210	322,161	233,455	989,826		989,826	(6,921)	982,905		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,708,700	136,500	23,667	1,868,867		1,868,867	58,931	1,927,798		10
10a	Therapy	25,475			25,475		25,475		25,475		10a
11	Activities	103,924	4,278	5,552	113,754		113,754	(374)	113,380		11
12	Social Services	46,992		4,647	51,639		51,639		51,639		12
13	CNA Training										13
14	Program Transportation			13,726	13,726		13,726		13,726		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,885,091	140,778	57,192	2,083,061		2,083,061	58,557	2,141,618		16
	C. General Administration										
17	Administrative	75,457			75,457		75,457	(2,867)	72,590		17
18	Directors Fees										18
19	Professional Services			116,223	116,223		116,223	23,116	139,339		19
20	Dues, Fees, Subscriptions & Promotions			75,231	75,231		75,231	(47,278)	27,953		20
21	Clerical & General Office Expenses	128,183	23,506	29,803	181,492		181,492	109,322	290,814		21
22	Employee Benefits & Payroll Taxes			402,269	402,269		402,269		402,269		22
23	Inservice Training & Education			1,584	1,584		1,584		1,584		23
24	Travel and Seminar			639	639		639	7,782	8,421		24
25	Other Admin. Staff Transportation			9,745	9,745		9,745		9,745		25
26	Insurance-Prop.Liab.Malpractice			146,982	146,982		146,982	10,651	157,633		26
27	Other (specify):*			1,670,489	1,670,489		1,670,489	(1,670,489)			27
28	TOTAL General Administration	203,640	23,506	2,452,965	2,680,111		2,680,111	(1,569,763)	1,110,348		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,522,941	486,445	2,743,612	5,752,998		5,752,998	(1,518,127)	4,234,871		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	9,810
	REPAIRS & MAINTENANCE	0
		0
		9,810
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	753
		0
		753
5	HEAT & OTHER UTILITIES	
	GAS HEAT	57,384
	ELECTRICITY	75,071
	WATER	15,307
	CABLE TV - LOBBY	0
		0
		147,762
6	MAINTENANCE	
	GROUNDS MAINTENANCE	18,817
	PAINTING & DECORATING	2,872
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,613
	ELEVATOR MAINTENANCE & REPAIR	4,592
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,930
	FIRE SERVICE	7,409
		0
		0
		0
		0
		54,233
7	OTHER	
	SCAVENGER	20,897
	SECURITY SERVICE	0
		0
		0
		20,897
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 ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,428
	PHARMACY CONSULTANT XVIII B 39-2	4,878
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 47-2	13,200
	RN CONSULTANT XVIII B 38-2	0
	ALZHEIMER CONSULTANT XVIII B 46-2	1,161
		0
		23,667
10a	THERAPY	
	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	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	2,659
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,893
		0
		5,552
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	4,062
	SOCIAL WORKER XVIII B 45-2	585
		0
		4,647
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	13,726
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	25,111
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	91,112
		0
		116,223
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	35,694
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,442
	EMPLOYEE WANT ADS XIX F	12,296
	CONTRIBUTIONS VI 20 XIX F	227
	DUES & SUBSCRIPTIONS XIX F	7,962
	LICENSES & PERMITS XIX F	2,576
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	365
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,157
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,144
	PATIENT BACKGROUND CHECKS XIX F	2,368
		75,231
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,702
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,655
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,669
	MESSENGER SERVICE	3,777
		0
		29,803

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	190,214
	UNEMPLOYMENT COMPENSATION XIX D	80,828
	WORKERS COMPENSATION INSURANC XIX D	56,703
	HOSPITALIZATION INSURANCE XIX D	70,337
	EMPLOYEE BENEFITS - OTHER XIX D	4,037
	EMPLOYEE PHYSICAL EXAMS XIX D	150
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		402,269
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,584
		1,584
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	639
		639
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,745
		9,745
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	146,982
		146,982
27	OTHER	
	BAD DEBTS VI 24	1,670,489
		1,670,489

GRAND TOTAL COLUMN 3 OTHER

2,743,612

**AMBERWOOD CARE CENTER
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	206,141
LESS SALES TAX	<u>(4,975)</u>
NET FOOD	201,166

TOTAL PATIENT CENSUS	32,766
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	98,298

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	98,298
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	98,298

NET FOOD	201,166
DIVIDE TOTAL MEALS/YEAR	<u>98,298</u>

COST PER MEAL	2.05
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number **AMBERWOOD CARE CENTER**

#0048504

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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			109,087	109,087	109,087	(85,834)	23,253				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			172,532	172,532	172,532		172,532				32
33	Real Estate Taxes			22,919	22,919	22,919		22,919				33
34	Rent-Facility & Grounds			300,000	300,000	300,000	(277,794)	22,206				34
35	Rent-Equipment & Vehicles			19,184	19,184	19,184	6,203	25,387				35
36	Other (specify):*											36
37	TOTAL Ownership			623,722	623,722	623,722	(357,425)	266,297				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,007	268,828	445,835	445,835		445,835				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,938	88,938	88,938		88,938				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		177,007	357,766	534,773	534,773		534,773				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,522,941	663,452	3,725,100	6,911,493	6,911,493	(1,875,552)	5,035,941				45

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

Facility Name & ID Number **AMBERWOOD CARE CENTER**

0048504

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

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	(88,619)	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	(4,975)	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	(3,655)	21		18
19	Entertainment	(35,694)	20		19
20	Contributions	(5,384)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(18,072)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,670,489)	27		24
25	Fund Raising, Advertising and Promotional	(6,442)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(365)	20		28
29	Other-Attach Schedule	(8,302)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,841,997)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(33,555)	PG 6-6C	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (33,555)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,875,552)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

AMBERWOOD CARE CENTER

ID# 0048504

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	VACATION ACCRUAL	(1,875)	1	2
3	VACATION ACCRUAL	477	3	3
4	VACATION ACCRUAL	(124)	4	4
5	VACATION ACCRUAL	(424)	6	5
6	VACATION ACCRUAL	4,331	10	6
7	VACATION ACCRUAL	(374)	11	7
8	VACATION ACCRUAL	(2,867)	17	8
9	VACATION ACCRUAL	(891)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B CONSULTANT		19	11
12	MARKETING CONSULTANT	(4,555)	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	(8,302)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD CARE CENTER# 0048504

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,875)	0	0	0	0	0	0	0	0	0	0	(1,875)	1
2	Food Purchase	(4,975)	0	0	0	0	0	0	0	0	0	0	(4,975)	2
3	Housekeeping	477	0	0	0	0	0	0	0	0	0	0	477	3
4	Laundry	(124)	0	0	0	0	0	0	0	0	0	0	(124)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(424)	0	0	0	0	0	0	0	0	0	0	(424)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,921)	0	0	0	0	0	0	0	0	0	0	(6,921)	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	4,331	0	0	54,600	0	0	0	0	0	0	0	58,931	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(374)	0	0	0	0	0	0	0	0	0	0	(374)	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	3,957	0	0	54,600	0	0	0	0	0	0	0	58,557	16
	C. General Administration													
17	Administrative	(2,867)	0	0	0	0	0	0	0	0	0	0	(2,867)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(24,627)	0	39,477	44	8,222	0	0	0	0	0	0	23,116	19
20	Fees, Subscriptions & Promotions	(47,885)	0	300	91	216	0	0	0	0	0	0	(47,278)	20
21	Clerical & General Office Expenses	(4,546)	0	9,191	1,614	103,063	0	0	0	0	0	0	109,322	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	2,700	2,354	2,728	0	0	0	0	0	0	7,782	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	954	1,224	8,473	0	0	0	0	0	0	10,651	26
27	Other (specify):*	(1,670,489)	0	0	0	0	0	0	0	0	0	0	(1,670,489)	27
28	TOTAL General Administration	(1,750,414)	0	52,622	5,327	122,702	0	0	0	0	0	0	(1,569,763)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,753,378)	0	52,622	59,927	122,702	0	0	0	0	0	0	(1,518,127)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(88,619)	0	277	114	2,394	0	0	0	0	0	0	(85,834)	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	0	22,206	0	0	0	0	0	0	(277,794)	34
35	Rent-Equipment & Vehicles	0	0	3,283	1,961	959	0	0	0	0	0	0	6,203	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(88,619)	(300,000)	3,560	2,075	25,559	0	0	0	0	0	0	(357,425)	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)	(1,841,997)	(300,000)	56,182	62,002	148,261	0	0	0	0	0	0	(1,875,552)	45

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 HEALTHCARE 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		\$ 39,477	\$ 39,477	15
16	V	20 DUES & SUBSCRIPTIONS		"		300	300	16
17	V	21 CLERICAL		"		9,191	9,191	17
18	V	24 TRAVEL		"		2,700	2,700	18
19	V	26 INSURANCE		"		954	954	19
20	V	35 RENT - EQPT & VEH		"		3,283	3,283	20
21	V							21
22	V	30 DEPRECIATION		"		277	277	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		\$			\$ 56,182	\$ * 56,182	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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		\$ 54,600	\$ 54,600	15
16	V	19	PROFESSIONAL FEES		"		44	44	16
17	V	20	DUES & SUBSCRIPTIONS		"		91	91	17
18	V	21	CLERICAL		"		1,614	1,614	18
19	V	24	TRAVEL		"		2,354	2,354	19
20	V	26	INSURANCE		"		1,224	1,224	20
21	V	30	DEPRECIATION		"		114	114	21
22	V	34	RENT		"				22
23	V	35	RENT - EQPT & VEH		"		1,961	1,961	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		\$				\$ 62,002	\$ * 62,002	39

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

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization						
15	V	19	PROFESSIONAL FEES	\$	THE KENSINGTON GROUP, LLC		\$ 8,222	\$ 8,222	15	
16	V	20	DUES & SUBSCRIPTIONS		" "		216	216	16	
17	V	21	CLERICAL		" "		103,063	103,063	17	
18	V	24	TRAVEL		" "		2,728	2,728	18	
19	V	26	INSURANCE		" "		8,473	8,473	19	
20	V	30	DEPRECIATION		" "		2,394	2,394	20	
21	V	34	RENT		" "		22,206	22,206	21	
22	V	35	RENT - EQPT & VEH		" "		959	959	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			\$			\$ 148,261	\$ * 148,261	39	

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

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 CARE CENTER

0048504

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	358,373	7	\$ 431,773	\$ 32,766	\$ 39,477	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	358,373	7	3,289	32,766	300	2
3	21	CLERICAL	PATIENT DAYS	358,373	7	100,522	32,766	9,191	3
4	24	TRAVEL	PATIENT DAYS	358,373	7	29,536	32,766	2,700	4
5	26	INSURANCE	PATIENT DAYS	358,373	7	10,431	32,766	954	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	358,373	7	35,906	32,766	3,283	6
7									7
8	30	DEPRECIATION	PATIENT DAYS	358,373	7	3,027	32,766	277	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					\$ 614,484	\$	\$ 56,182	25

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	\$ 54,600	\$ 54,600	1	\$ 54,600	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	11	744	32,766	44	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	1,552	32,766	91	3
4	21	CLERICAL	PATIENT DAYS	554,294	11	27,317	32,766	1,614	4
5	24	TRAVEL	PATIENT DAYS	554,294	11	39,814	32,766	2,354	5
6	26	INSURANCE	PATIENT DAYS	554,294	11	20,700	32,766	1,224	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	11	1,923	32,766	114	7
8	34	RENT	PATIENT DAYS	554,294	11		32,766		8
9	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	33,179	32,766	1,961	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				\$ 179,829	\$ 54,600		\$ 62,002	25

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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 THE KENSINGTON GROUP, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0110
 Fax Number (847) 583-8873

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	554,294	11	\$ 139,104	\$ 32,766	\$ 8,222	1	
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	32,766	216	2	
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	32,766	10,761	3	
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	32,766	2,728	4	
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	32,766	8,473	5	
6	30	DPERECIATION	PATIENT DAYS	554,294	11	40,500	32,766	2,394	6	
7	34	RENT	PATIENT DAYS	554,294	11	375,668	32,766	22,206	7	
8	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	16,218	32,766	959	8	
9									9	
10	21	CLERICAL	DIRECT COST	1	1	92,302	92,302	1	92,302	10
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,039,007	\$ 92,302	\$ 148,261	25	

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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										
										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																			
2																			
3																			
4																			
5																			
Working Capital																			
6	ALBANK		X	WORKING CAPITAL	DEMAND	12/06	1,200,000	1,250,000	DEMAND	PRIME +	45,747								
7	CHESTERFIELD	X		WORKING CAPITAL	DEMAND	12/06	1,588,219	2,149,219	DEMAND	VARIES	115,146								
8	WITTINGHAM	X		WORKING CAPITAL	DEMAND	12/07	593,000	543,000	DEMAND	VARIES	11,639								
9	TOTAL Facility Related						\$ 3,381,219	\$ 3,942,219			\$ 172,532								
B. Non-Facility Related*																			
10	IRS, IDR, ETC		X	LATE FEES															
11																			
12																			
13																			
14	TOTAL Non-Facility Related						\$	\$			\$								
15	TOTALS (line 9+line14)						\$ 3,381,219	\$ 3,942,219			\$ 172,532								

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.)

Facility Name & ID Number **AMBERWOOD CARE CENTER**

0048504 Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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 2007 report.		\$	72,153	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.)		\$	47,119	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(25,034)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	47,953	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.		\$	22,919	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003			8
	2004			9
	2005			10
	2006	37,926		11
	2007	47,119		12
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 2007 TAX BILL				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBERWOOD CARE CENTER COUNTY WINNEBAGO COUNTY

FACILITY IDPH LICENSE NUMBER 0048504

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 2007 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 2007.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-11-354-001</u>	<u>NURSING HOME</u>	\$ <u>47,118.92</u>	\$ <u>47,118.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>47,118.92</u>	\$ <u>47,118.92</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		FLUSH STEEL DOOR WITH MISCO WIRE GLASS		2006	2,010	74	27.5	74		168	9
10		METAL DOOR WITH FULL MORTISE HINGE		2006	1,784	65	27.5	65		143	10
11		WHEEL CHAIR RAMPS		2006	2,650	97	27.5	97		213	11
12		DRYWALL FRAME; INSULATED METAL DOOR		2006	1,070	39	27.5	39		86	12
13		REMOVE & REPLACE 7 SECTIONS OF CONCRETE SIDWALK		2006	1,950	71	27.5	71		151	13
14		REMOVE OLD & INSTALL NEW ALUMINUM SIGNS		2006	4,135	150	27.5	150		307	14
15		DOOR PROTECTIVE DEVICES ON 2 PASSENGER ELEVATORS		2007	2,300	83	27.5	83		160	15
16		PANELS, VALENCES & BORDERS - 2ND FLOOR		2007	11,346	1,135	10	1,135		1,891	16
17		TILES & GROUT - 2ND FLOOR		2007	8,622	313	27.5	313		444	17
18		TOILETS - 2ND FLOOR		2007	646	23	27.5	23		33	18
19		2 BARRIER FREE SHOWERS		2007	3,998	145	27.5	145		206	19
20		TILES - 2ND FLOOR		2007	939	34	27.5	34		43	20
21		BREAKFING OUT CONCRETE AND INSTALL NEW DRAIN		2007	734	26	27.5	26		33	21
22		CUSTOM FORM QVC FRAME GUARDS - 2ND FLOOR		2007	3,845	140	27.5	140		175	22
23		INSULATED METAL DOOR & DRYWALL FRAMES		2008	27,604	836	27.5	836		836	23
24		EXIT SIGNS		2008	1,029	25	27.5	25		25	24
25		FIRE DOORS AND PARTS		2008	6,450	117	27.5	117		117	25
26		EXHAUST PIPING FOR INTAKE FANS		2008	4,314	92	27.5	92		92	26
27		CARPET		2008	1,600	320	5	187	(133)	187	27
28		INSTALLED 21 SMOKE DETECTORS		2008	5,000	106	27.5	106		106	28
29		CUBICLE CURTAINS		2008	3,530	706	5	353	(353)	353	29
30		LIGHT FIXTURES		2008	3,048	18	27.5	18		18	30
31		VINYL WALLCOVERING		2008	1,831	366	5	61	(305)	61	31
32		LACE FLOORING - DINING AREAS		2008	2,897	579	5	97	(482)	97	32
33		KITCHEN AREA - REMODEL TO PLACE NEW EQUIPMENT		2008	41,327	250	27.5	250		250	33
34		SUPPLIES FOR KITCHEN REMODELING		2008	1,088	7	27.5	7		7	34
35		LIGHTING FOR KITCHEN		2008	702	2	27.5	2		2	35
36		PVC DRAIN PIPES FOR KITCHEN SINK		2008	1,015	3	27.5	3		3	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	FLOORS - ACTIVITY ROOM & CENTRAL NURSES STATION	2008	\$ 7,206	\$ 1,441	5	\$	\$ (1,441)	\$
38								
39								
40								
41								
42								
43								
44								
45								
46								
47								
48								
49								
50								
51								
52								
53								
54								
55								
56								
57								
58								
59								
60								
61								
62								
63								
64								
65								
66								
67								
68								
69								
70	TOTAL (lines 4 thru 69)		\$ 154,670	\$ 7,263		\$ 4,549	\$ (2,714)	\$ 6,207

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

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$ 109,464	\$ 28,338	\$ 12,694	\$ (15,644)		\$ 12,435	71
72	Current Year Purchases	135,845	73,486	3,225	(70,261)			72
73	Fully Depreciated Assets							73
74	<u>RELATED PARTY</u>		2,785	2,785				74
75	TOTALS	\$ 245,309	\$ 104,609	\$ 18,704	\$ (85,905)		\$ 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	2	
	Reference	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)	\$ 559,979	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 111,872	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,253	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (88,619)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,642	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number AMBERWOOD CARE CENTER

0048504

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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: \$ 12,540

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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. /2009 \$ _____

13. /2010 \$ _____

14. /2011 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>ADMINISTRATIVE</u>	<u>2005 TOYOTA CAMRY</u>	\$ <u>489.67</u>	\$ <u>6,644</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>489.67</u>	\$ <u>6,644</u>	21

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

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

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?</p> <p><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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility	1 2 3 4			
		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	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
					Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$				\$ 133,975	\$			\$ 133,975	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs					8,644				8,644	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-3	hrs					126,209				126,209	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						107,683			107,683	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	MEDICAL SUPPLIES, XRAY,LAB Other (specify): RENTALS, I.V. TPY	39-2							69,324			69,324	13	
14	TOTAL			\$				\$ 268,828	\$	177,007		\$ 445,835	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 CARE CENTER# 0048504Report Period Beginning: 01/01/2008Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 60,098	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,350,609</u>)	1,806,323		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,261		6
7	Other Prepaid Expenses	3,148		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,963,830	\$	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	154,670		15
16	Equipment, at Historical Cost	245,307		16
17	Accumulated Depreciation (book methods)	(150,824)		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)	\$ 249,153	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,212,983	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,161,495	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,027		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,521		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,804		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,953		32
33	Accrued Interest Payable	16,815		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)	\$ 2,395,615	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,057,219		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)	\$ 4,057,219	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,452,834	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (4,239,851)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,212,983	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,776,002)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,775,999)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,463,852)	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)	\$ (2,463,852)	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)	\$ (4,239,851)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **AMBERWOOD CARE CENTER**

0048504

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

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	\$ 4,447,641	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,447,641	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		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)	\$	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		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,447,641	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	989,826	31
32	Health Care	2,083,061	32
33	General Administration	2,680,111	33
B. Capital Expense			
34	Ownership	623,722	34
C. Ancillary Expense			
35	Special Cost Centers	445,835	35
36	Provider Participation Fee	88,938	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,911,493	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,463,852)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,463,852)	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 CARE CENTER**

0048504

Report Period Beginning: **01/01/2008**

Ending:

12/31/2008

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	3,429	3,647	\$ 169,901	\$ 46.59	1
2	Assistant Director of Nursing	1,051	1,085	33,570	30.94	2
3	Registered Nurses	8,641	9,136	232,326	25.43	3
4	Licensed Practical Nurses	20,578	22,258	502,407	22.57	4
5	CNAs & Orderlies	68,274	73,252	690,159	9.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,261	2,525	25,475	10.09	8
9	Activity Director	1,953	2,091	33,463	16.00	9
10	Activity Assistants	8,574	9,177	70,461	7.68	10
11	Social Service Workers	2,376	2,432	46,992	19.32	11
12	Dietician					12
13	Food Service Supervisor	3,113	3,210	52,447	16.34	13
14	Head Cook	732	756	6,873	9.09	14
15	Cook Helpers/Assistants	17,119	18,169	147,262	8.11	15
16	Dishwashers					16
17	Maintenance Workers	6,510	6,926	71,185	10.28	17
18	Housekeepers	13,210	14,131	122,053	8.64	18
19	Laundry	4,213	4,485	34,390	7.67	19
20	Administrator	2,041	2,091	75,457	36.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	911	1,003	18,009	17.96	23
24	Clerical	7,663	8,221	110,174	13.40	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	3,650	3,950	80,337	20.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,299	188,545	\$ 2,522,941 *	\$ 13.38	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	160	\$ 9,810	1-3	35
36	Medical Director	96	9,600	9-3	36
37	Medical Records Consultant	66	4,428	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	96	4,878	10-3	39
40	Physical Therapy Consultant			10a-3	40
41	Occupational Therapy Consultant			10a-3	41
42	Respiratory Therapy Consultant			10a-3	42
43	Speech Therapy Consultant			10a-3	43
44	Activity Consultant	43	2,893	11-3	44
45	Social Service Consultant	66	4,647	12-3	45
46	Other(specify) <u>ALZHEIMERS</u>	17	1,161	10-3	46
47	<u>PSYCHIATRIC</u>	96	13,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	640	\$ 50,617		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JULIE LOGAN	ADMINISTRATOR		\$ 75,457	Workers' Compensation Insurance	\$ 56,703	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	80,828	Advertising: Employee Recruitment	12,296	
	OTHER ADMIN		0	FICA Taxes	190,214	Health Care Worker Background Check	2,144	
				Employee Health Insurance	70,337	(Indicate # of checks performed <u>134</u>)		
				Employee Meals	0	Patient Background Checks <u>148</u>	2,368	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	5,384	
				EMPLOYEE BENEFITS - OTHER	4,037	MARKETING/ADV/PROMO	42,501	
				EMPLOYEE PHYSICAL EXAMS	150	LICENSES/DUES/SUBSCRIPTIONS	10,538	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	607	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 75,457	CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(5,384)	
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(35,694)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(6,442)	
						Yellow page advertising	(365)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 402,269	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 27,953	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
							TRAVEL	639
							RELATED PARTY	7,782
							Seminar Expense	
								0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 8,421
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			116,223					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 116,223					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number AMBERWOOD CARE CENTER# 0048504Report Period Beginning: 01/01/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL. COUNCIL ON LTC - \$8229.6
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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. \$ 1,936 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. \$ 88,938
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.