



Facility Name & ID Number AMBERWOOD CARE CENTER

# 0048504 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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	7,942	527	3,617	12,086	8
9	SNF/PED					9
10	ICF	17,133	1,138	2,802	21,073	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,075	1,665	6,419	33,159	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.08%**

**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 2,318

Medicare Intermediary NATIONAL GOV'T SERVICES

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

AMBERWOOD CARE CENTER

# 0048504

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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
	<b>A. General Services</b>										
1	Dietary	193,661	25,828	9,506	228,995		228,995	1,912	230,907		1
2	Food Purchase		217,030		217,030		217,030	(2,601)	214,429		2
3	Housekeeping	117,307	22,913		140,220		140,220	(469)	139,751		3
4	Laundry	33,986	18,178		52,164		52,164	261	52,425		4
5	Heat and Other Utilities			130,264	130,264		130,264		130,264		5
6	Maintenance	50,868	31,377	71,120	153,365		153,365	(151)	153,214		6
7	Other (specify):*			22,858	22,858		22,858		22,858		7
8	<b>TOTAL General Services</b>	395,822	315,326	233,748	944,896		944,896	(1,048)	943,848		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,693,725	101,240	27,517	1,822,482		1,822,482	70,489	1,892,971		10
10a	Therapy	27,010		130	27,140		27,140		27,140		10a
11	Activities	106,805	2,724	6,345	115,874		115,874	95	115,969		11
12	Social Services			13,262	13,262		13,262		13,262		12
13	CNA Training										13
14	Program Transportation			3,950	3,950		3,950		3,950		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,827,540	103,964	60,804	1,992,308		1,992,308	70,584	2,062,892		16
	<b>C. General Administration</b>										
17	Administrative	75,275			75,275		75,275	(2,367)	72,908		17
18	Directors Fees										18
19	Professional Services			76,408	76,408		76,408	70,517	146,925		19
20	Dues, Fees, Subscriptions & Promotions			117,290	117,290		117,290	(81,091)	36,199		20
21	Clerical & General Office Expenses	92,313	23,075	43,464	158,852		158,852	133,360	292,212		21
22	Employee Benefits & Payroll Taxes			390,209	390,209		390,209		390,209		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,108	4,108		4,108	8,073	12,181		24
25	Other Admin. Staff Transportation			5,114	5,114		5,114		5,114		25
26	Insurance-Prop.Liab.Malpractice			250,770	250,770		250,770	3,562	254,332		26
27	Other (specify):*			250,761	250,761		250,761	(250,761)			27
28	<b>TOTAL General Administration</b>	167,588	23,075	1,138,124	1,328,787		1,328,787	(118,707)	1,210,080		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,390,950	442,365	1,432,676	4,265,991		4,265,991	(49,171)	4,216,820		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,506
	REPAIRS & MAINTENANCE	0
		0
		9,506
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	44,214
	ELECTRICITY	64,940
	WATER	21,110
	CABLE TV - LOBBY	0
		0
		130,264
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	21,133
	PAINTING & DECORATING	5,809
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	29,215
	ELEVATOR MAINTENANCE & REPAIR	5,460
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,681
	FIRE SERVICE	4,822
		0
		0
		0
		0
		71,120
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	22,858
	SECURITY SERVICE	0
		0
		0
		22,858
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,600
		9,600

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	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	5,130
	PHARMACY CONSULTANT XVIII B 39-2	4,905
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B 47-2	13,500
	RN CONSULTANT XVIII B 38-2	0
	ALZHEIMERS CONSULTANT XVIII B 46-2	3,982
		0
		27,517
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	130
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		130
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	2,729
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,616
		0
		6,345
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	13,262
	SOCIAL WORKER XVIII B 45-2	0
		0
		13,262
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	3,950
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
18	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	22,843
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	53,565
		0
		76,408
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	66,415
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,923
	EMPLOYEE WANT ADS XIX F	20,040
	CONTRIBUTIONS VI 20 XIX F	750
	DUES & SUBSCRIPTIONS XIX F	9,282
	LICENSES & PERMITS XIX F	2,022
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	7,512
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,208
	PATIENT BACKGROUND CHECKS XIX F	2,138
		117,290
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,641
	EQUIPMENT REPAIR & MAINTENANCE	536
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	11,701
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,810
	MESSENGER SERVICE	3,776
		0
		43,464

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	180,803
	UNEMPLOYMENT COMPENSATION XIX D	50,769
	WORKERS COMPENSATION INSURANCE XIX D	57,690
	HOSPITALIZATION INSURANCE XIX D	97,931
	EMPLOYEE BENEFITS - OTHER XIX D	1,854
	EMPLOYEE PHYSICAL EXAMS XIX D	1,162
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		390,209
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	3,764
	TRAVEL XIX G	344
		4,108
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	5,114
		5,114
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	250,770
		250,770
27	<b>OTHER</b>	
	BAD DEBTS VI 24	250,761
		250,761

GRAND TOTAL COLUMN 3 OTHER

1,432,676

**AMBERWOOD CARE CENTER  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	217,030
LESS SALES TAX	<u>(2,601)</u>
NET FOOD	214,429
TOTAL PATIENT CENSUS	33,159
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	99,477
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	99,477
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	99,477
NET FOOD	214,429
DIVIDE TOTAL MEALS/YEAR	<u>99,477</u>
COST PER MEAL	2.16
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>
	=====

Facility Name &amp; ID Number

AMBERWOOD CARE CENTER

#0048504

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	
	<b>D. Ownership</b>											
30	Depreciation			83,615	83,615		83,615	(33,666)	49,949			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,214	32,214		32,214	(3,750)	28,464			32
33	Real Estate Taxes			55,180	55,180		55,180		55,180			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(273,115)	26,885			34
35	Rent-Equipment & Vehicles			32,767	32,767		32,767	7,080	39,847			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			503,776	503,776		503,776	(303,451)	200,325			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,677	262,439	470,116		470,116		470,116			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	<b>TOTAL Special Cost Centers</b>		207,677	351,134	558,811		558,811		558,811			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,390,950	650,042	2,287,586	5,328,578		5,328,578	(352,622)	4,975,956			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:

**01/01/2009**

Ending:

**12/31/2009**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(46,398)	30		9
10	Interest and Other Investment Income	(3,750)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,601)	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	(11,701)	21		18
19	Entertainment	(66,415)	20		19
20	Contributions	(8,262)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,414)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(250,761)	27		24
25	Fund Raising, Advertising and Promotional	(6,923)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(3,955)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (402,180)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	
							52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	49,558	PG 6-6C	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 49,558		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (352,622)		37

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

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

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

ID# 0048504

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$	6	1
2	VACATION ACCRUAL	1,912	1	2
3	VACATION ACCRUAL	(469)	3	3
4	VACATION ACCRUAL	261	4	4
5	VACATION ACCRUAL	(151)	6	5
6	VACATION ACCRUAL	1,864	10	6
7	VACATION ACCRUAL	95	11	7
8	VACATION ACCRUAL	(2,367)	17	8
9	VACATION ACCRUAL	2,395	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B CONSULTANT		19	11
12	MARKETING CONSULTANT	(5,495)	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	<b>Total</b>	(3,955)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD CARE CENTER# 0048504

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	1,912	0	0	0	0	0	0	0	0	0	0	1,912	1
2	Food Purchase	(2,601)	0	0	0	0	0	0	0	0	0	0	(2,601)	2
3	Housekeeping	(469)	0	0	0	0	0	0	0	0	0	0	(469)	3
4	Laundry	261	0	0	0	0	0	0	0	0	0	0	261	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(151)	0	0	0	0	0	0	0	0	0	0	(151)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,048)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,048)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	1,864	0	0	68,625	0	0	0	0	0	0	0	70,489	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	95	0	0	0	0	0	0	0	0	0	0	95	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>1,959</b>	<b>0</b>	<b>0</b>	<b>68,625</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>70,584</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(2,367)	0	0	0	0	0	0	0	0	0	0	(2,367)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,909)	0	77,351	583	1,492	0	0	0	0	0	0	70,517	19
20	Fees, Subscriptions & Promotions	(81,600)	0	111	36	362	0	0	0	0	0	0	(81,091)	20
21	Clerical & General Office Expenses	(9,306)	0	6,281	1,298	135,087	0	0	0	0	0	0	133,360	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	1,948	2,580	3,545	0	0	0	0	0	0	8,073	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	836	1,136	1,590	0	0	0	0	0	0	3,562	26
27	Other (specify):*	(250,761)	0	0	0	0	0	0	0	0	0	0	(250,761)	27
28	<b>TOTAL General Administration</b>	<b>(352,943)</b>	<b>0</b>	<b>86,527</b>	<b>5,633</b>	<b>142,076</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(118,707)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(352,032)</b>	<b>0</b>	<b>86,527</b>	<b>74,258</b>	<b>142,076</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(49,171)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD CARE CENTER# 0048504

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

## 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	(46,398)	9,327	625	223	2,557	0	0	0	0	0	0	(33,666)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,750)	0	0	0	0	0	0	0	0	0	0	(3,750)	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	983	25,902	0	0	0	0	0	0	(273,115)	34
35	Rent-Equipment & Vehicles	0	0	3,303	2,959	818	0	0	0	0	0	0	7,080	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(50,148)</b>	<b>(290,673)</b>	<b>3,928</b>	<b>4,165</b>	<b>29,277</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(303,451)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(402,180)</b>	<b>(290,673)</b>	<b>90,455</b>	<b>78,423</b>	<b>171,353</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(352,622)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>ROCKTON GROUP, INC</u>	<u>100</u>	<u>SEE ATTACHED LIST OF RELATED NURSING HOMES</u>		<u>AMBERWOOD HEALTHCARE CENTRE</u>		<u>REAL ESTATE</u>
				<u>SEE ATTACHED LIST OF OTHER RELATED ENTITIES</u>		

**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)	
<u>1</u>	<u>V</u>	<u>34 RENT</u>	<u>\$ 300,000</u>	<u>AMBERWOOD HEALTH CARE CENTRE</u>		<u>\$</u>	<u>(300,000)</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>30 DEPRECIATION - BLDS/IMP</u>		<u>" "</u>		<u>9,327</u>	<u>9,327</u>	<u>2</u>
<u>3</u>	<u>V</u>							<u>3</u>
<u>4</u>	<u>V</u>							<u>4</u>
<u>5</u>	<u>V</u>							<u>5</u>
<u>6</u>	<u>V</u>							<u>6</u>
<u>7</u>	<u>V</u>							<u>7</u>
<u>8</u>	<u>V</u>							<u>8</u>
<u>9</u>	<u>V</u>							<u>9</u>
<u>10</u>	<u>V</u>							<u>10</u>
<u>11</u>	<u>V</u>							<u>11</u>
<u>12</u>	<u>V</u>							<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	<b>Total</b>		<b>\$ 300,000</b>			<b>\$ 9,327</b>	<b>\$ * (290,673)</b>	<b>14</b>

\* 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		\$ 77,351	\$ 77,351	15
16	V	20	DUES & SUBSCRIPTIONS		" "		111	111	16
17	V	21	CLERICAL		" "		6,281	6,281	17
18	V	24	TRAVEL		" "		1,948	1,948	18
19	V	26	INSURANCE		" "		836	836	19
20	V	35	RENT - EQPT & VEH		" "		3,303	3,303	20
21	V	30	DEPRECIATION		" "		625	625	21
22	V								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			\$			\$ 90,455	\$ * 90,455	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		\$ 68,625	\$ 68,625	15	
16	V	19	PROFESSIONAL FEES		" "		583	583	16	
17	V	20	DUES & SUBSCRIPTIONS		" "		36	36	17	
18	V	21	CLERICAL		" "		1,298	1,298	18	
19	V	24	TRAVEL		" "		2,580	2,580	19	
20	V	26	INSURANCE		" "		1,136	1,136	20	
21	V	30	DEPRECIATION		" "		223	223	21	
22	V	34	RENT		" "		983	983	22	
23	V	35	RENT - EQPT & VEH.		" "		2,959	2,959	23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$			\$ 78,423	\$ *	78,423	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		\$ 1,492	\$	1,492	15
16	V	20	DUES & SUBSCRIPTIONS		" "		362		362	16
17	V	21	CLERICAL		" "		135,087		135,087	17
18	V	24	TRAVEL		" "		3,545		3,545	18
19	V	26	INSURANCE		" "		1,590		1,590	19
20	V	30	DEPRECIATION		" "		2,557		2,557	20
21	V	34	RENT		" "		25,902		25,902	21
22	V	35	RENT - EQPT & VEH.		" "		818		818	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			\$			\$ 171,353	\$ *	171,353	39

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

Facility Name &amp; ID Number

AMBERWOOD CARE CENTER

#

0048504

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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:

01/01/2009

Ending: 2/31/2009

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	355,386	7	\$ 829,056	\$ 33,159	\$ 77,351	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	355,386	7	1,188	33,159	111	2
3	21	CLERICAL	PATIENT DAYS	355,386	7	67,323	33,159	6,281	3
4	24	TRAVEL	PATIENT DAYS	355,386	7	20,875	33,159	1,948	4
5	26	INSURANCE	PATIENT DAYS	355,386	7	8,960	33,159	836	5
6	35	RENT - EQPT & VEH.	PATIENT DAYS	355,386	7	35,397	33,159	3,303	6
7	30	DEPRECIATION	PATIENT DAYS	355,386	7	6,701	33,159	625	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 969,500	\$	\$ 90,455	25

Facility Name & ID Number AMBERWOOD CARE CENTER

# 0048504

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	\$ 68,625	\$ 68,625	1	\$ 68,625	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	9,656	33,159	583	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	603	33,159	36	3
4	21	CLERICAL	PATIENT DAYS	549,185	11	21,492	33,159	1,298	4
5	24	TRAVEL	PATIENT DAYS	549,185	11	42,708	33,159	2,580	5
6	26	INSURANCE	PATIENT DAYS	549,185	11	18,809	33,159	1,136	6
7	30	DEPRECIATION	PATIENT DAYS	549,185	11	3,694	33,159	223	7
8	34	RENT	PATIENT DAYS	549,185	11	16,279	33,159	983	8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	549,185	11	48,990	33,159	2,959	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				\$ 230,856	\$ 68,625		\$ 78,423	25

Facility Name & ID Number AMBERWOOD CARE CENTER

# 0048504

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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) 583-0100  
 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	549,185	11	\$ 24,702	\$ 33,159	\$ 1,492	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	6,002	33,159	362	2
3	21	CLERICAL	PATIENT DAYS	549,185	11	215,149	33,159	12,991	3
4	24	TRAVEL	PATIENT DAYS	549,185	11	58,719	33,159	3,545	4
5	26	INSURANCE	PATIENT DAYS	549,185	11	26,340	33,159	1,590	5
6	30	DEPRECIATION	PATIENT DAYS	549,185	11	42,349	33,159	2,557	6
7	34	RENT	PATIENT DAYS	549,185	11	428,990	33,159	25,902	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	549,185	11	13,546	33,159	818	8
9	21	CLERICAL	DIRECT COST	1	1	122,096	122,096	1	122,096
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					\$ 937,893	\$ 122,096	\$ 171,353	25

Facility Name & ID Number AMBERWOOD CARE CENTER

# 0048504

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1																			
2																			
3																			
4																			
5																			
<b>Working Capital</b>																			
6		X	WORKING CAPITAL	DEMAND	12/06	1,200,000	1,250,000	DEMAND	PRIME +	20,330									
7		X	WORKING CAPITAL	DEMAND	12/08	100,000	67,361	DEMAND	VARIES	9,455									
8	X		WORKING CAPITAL	DEMAND	12/06	2,181,219	3,219,219	DEMAND	VARIES	2,429									
9						\$ 3,481,219	\$ 4,536,580			\$ 32,214									
<b>B. Non-Facility Related*</b>																			
10		X	LATE FEES																
11																			
12																			
13																			
14						\$	\$			\$									
15						\$ 3,481,219	\$ 4,536,580			\$ 32,214									

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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>47,953</b>	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.)		\$	<b>50,180</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,227</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>52,953</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>55,180</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004		8
	2005		9
	2006	<b>37,926</b>	10
	2007	<b>47,119</b>	11
	2008	<b>50,180</b>	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 2008 TAX BILL**

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 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 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<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>50,179.68</u>	\$ <u>50,179.68</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>50,179.68</u>	\$ <u>50,179.68</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

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

# **0048504**

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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

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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>NURSING HOME</u>	<u>39,171</u>	<u>1994</u>	<u>\$ 171,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>39,171</b>		<b>\$ 171,000</b>	<b>3</b>

Facility Name & ID Number AMBERWOOD CARE CENTER# 0048504

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**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
	<b>Improvement Type**</b>										
9		FLUSH STEEL DOOR WITH MISCO WIRE GLASS	2006		2,010	73	27.5	73		241	9
10		METAL DOOR WITH FULL MORTISE HINGE	2006		1,784	65	27.5	65		208	10
11		WHEEL CHAIR RAMPS	2006		2,650	96	27.5	96		309	11
12		DRYWALL FRAME; INSULATED METAL DOOR	2006		1,070	39	27.5	39		125	12
13		REMOVE & REPLACE 7 SECTIONS OF CONCRETE SIDEWALK	2006		1,950	71	27.5	71		222	13
14		REMOVE OLD & INSTAL NEW ALUMINUM SIGNS	2006		4,135	150	27.5	150		457	14
15		DOOR PROTECTIVE DEVICES ON 2 PASSENGER ELEVATORS	2004		2,300	84	27.5	84		244	15
16		PANELS. VALENCES & BORDER - 2ND FLOOR	2007		11,346	1,135	10	1,135		3,026	16
17		TILES & GROUT - 2ND FLOOR	2007		8,622	314	27.5	314		758	17
18		TOILETS - 2ND FLOOR	2007		646	24	27.5	24		57	18
19		2 BARRIER FREE SHOWERS	2007		3,998	145	27.5	145		351	19
20		TILES - 2ND FLOOR	2007		939	34	27.5	34		77	20
21		BREAKING OUT CONCRETE AND INSTALL NEW DRAIN	2007		734	27	27.5	27		60	21
22		CUSTOM FORM QVC FRAME GUARDS - 2ND FLOOR	2007		3,845	140	27.5	140		315	22
23		INSULATED METAL DOOR & DRYWALL FRAMES	2008		27,604	1,004	27.5	1,004		1,840	23
24		EXIT SIGNS	2008		1,029	37	27.5	37		62	24
25		FIRE DOORS AND PARTS	2008		6,450	235	27.5	235		352	25
26		EXHAUST PIPING FOR INTAKE FANS	2008		4,314	156	27.5	156		248	26
27		CARPET	2008		1,600	512	5	320	(192)	507	27
28		INSTALLED 21 SMOKE DETECTORS	2008		5,000	182	27.5	182		288	28
29		CUBICLE CURTAINS	2008		3,530	1,130	5	706	(424)	1,059	29
30		LIGHT FIXTURES	2008		3,048	111	27.5	111		129	30
31		VINYL WALLCOVERING	2008		1,831	586	5	366	(220)	427	31
32		LACE FLOORING - DINING AREAS	2008		2,897	928	5	579	(349)	676	32
33		KITCHEN AREA - REMODEL TO PLACE NEW EQUIPMENT	2008		41,327	1,503	27.5	1,503		1,753	33
34		SUPPLIES FOR KITCHEN REMODELING	2008		1,088	39	27.5	39		46	34
35		LIGHTING FOR KITCHEN	2008		702	26	27.5	26		28	35
36		PVC DRAIN PIPES FOR KITCHEN SINK	2008		1,015	37	27.5	37		40	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number AMBERWOOD CARE CENTER# 0048504

Report Period Beginning:

01/01/2009 Ending: 12/31/2009**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	\$ 2,306	5	\$ 1,441	\$ (865)	\$ 1,441	37
38 RUN ADTL GAS & ELECTRIC LINES/REBUILD WALL								38
39 BEHIND FREEZER	2009	5,000	91	27.5	91		91	39
40 INSTALL 2 BACKFLOW DEVICES, GENERATOR AND RUN								40
41 UNDERGROUND POWER WIRE	2009	19,591	59	27.5	59		59	41
42								42
43 ***RELATED PARTY - AMBERWOOD HEALTH CARE CENTRE, INC.***								43
44 PAINT & PUT BORDER FOR ROOMS 216 THRU 264	2009	54,300	1,974	27.5	1,974		1,974	44
45 REMOVE & INSTALL APPROX. 50 DOORS AND PAINT THEM	2009	55,050	2,002	27.5	2,002		2,002	45
46 CONVERT MED ROOM TO NURSES STATION	2009	32,000	1,067	27.5	1,067		1,067	46
47 DEMOLISH & RENOVATE ALZHEIMERS WING ACTIVITY								47
48 ROOM & NURSES STATION	2009	17,600	1,490	10	1,490		1,490	48
49 INSTALL DRYWALL & CAULK AREAS IN THE BASEMENT								49
50 PER LIFE SAFETY CODE	2009	10,000	364	27.5	364		364	50
51 ALZHEIMER'S UNIT - INSTALL NEW DOOR, REPAIR SHOWER								51
52 ROMM, STRIP & PAINT ALL RES. ROOMS IN THE WING	2009	12,800	465	27.5	465		465	52
53 STRIP & PAINT FRONT LOBBY/VISTIBULE DOORS & FRAM	2009	10,000	364	27.5	364		364	53
54 REPAIR & PAINT-PUBLIC RESTROOM, FAMILY ROOM								54
55 COVE BASE, 2ND FLOOR EMPLOYEE RESTROOM	2009	10,450	478	27.5	478		478	55
56 REPAIR & PAINT/PUT BORDER FOR RMS 140 THRU 170 &								56
57 DOOR REPLACEMENT	2009	33,700	1,123	10	1,123		1,123	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)		\$ 415,161	\$ 20,666		\$ 18,616	\$ (2,050)	\$ 24,823	70

\*\*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:

**01/01/2009**

Ending:

**12/31/2009**

**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	\$ 245,309	\$ 42,743	\$ 26,077	\$ (16,666)		\$ 239,717	71
72	Current Year Purchases	52,539	29,533	1,851	(27,682)		1,851	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>		3,405	3,405				74
75	<b>TOTALS</b>	\$ 297,848	\$ 75,681	\$ 31,333	\$ (44,348)		\$ 241,568	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 884,009	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,347	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,949	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (46,398)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 266,391	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	<b>TOTALS</b>	\$	\$	\$	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	<b>TOTAL</b>				\$			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: \$ 27,070 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	<u>ADMINISTRATIVE</u>	<u>2005 TOYOTA CAMRY</u>	\$ <u>479.00</u>	\$ <u>5,697</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>479.00</u>	\$ <u>5,697</u>	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 127,733	\$		\$ 127,733	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,719			12,719	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			121,987			121,987	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				100,529		100,529	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): <b>RENTALS, I.V. TPY</b>	39-2					107,148		107,148	13
14	<b>TOTAL</b>			\$		\$ 262,439	\$ 207,677		\$ 470,116	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**# **0048504**Report Period Beginning: **01/01/2009**

Ending:

**12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 78,908	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,828,066		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,580		6
7	Other Prepaid Expenses	3,832		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,055,386	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	179,261		15
16	Equipment, at Historical Cost	297,846		16
17	Accumulated Depreciation (book methods)	(234,439)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 242,668	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,298,054	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,195,641	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,989		28
29	Short-Term Notes Payable	67,361		29
30	Accrued Salaries Payable	103,441		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,061		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,953		32
33	Accrued Interest Payable	16,815		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,472,261	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	4,469,219		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 4,469,219	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,941,480	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (4,643,426)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,298,054	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(4,239,851)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING ADJ.</b>	<b>7</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(4,239,844)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(403,582)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(403,582)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(4,643,426)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,934,070	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,934,070	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,750	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,750	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>NET VENDING COMMISSIONS</b>	157	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 157	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,937,977	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	944,896	31
32	Health Care	1,992,308	32
33	General Administration	1,328,787	33
<b>B. Capital Expense</b>			
34	Ownership	503,776	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	470,116	35
36	Provider Participation Fee	88,695	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>	12,981	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,341,559	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(403,582)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (403,582)	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:

**01/01/2009**

Ending:

**12/31/2009**

**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	2,146	2,291	\$ 124,304	\$ 54.26	1
2	Assistant Director of Nursing	3,442	3,821	120,843	31.63	2
3	Registered Nurses	6,903	7,409	189,403	25.56	3
4	Licensed Practical Nurses	21,399	22,989	519,448	22.60	4
5	CNAs & Orderlies	57,784	63,075	591,995	9.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,410	2,663	27,010	10.14	8
9	Activity Director	1,973	2,086	33,371	16.00	9
10	Activity Assistants	8,515	9,213	73,434	7.97	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,962	4,261	60,428	14.18	13
14	Head Cook	2,561	2,851	25,673	9.00	14
15	Cook Helpers/Assistants	12,282	13,066	107,560	8.23	15
16	Dishwashers					16
17	Maintenance Workers	3,784	4,061	50,868	12.53	17
18	Housekeepers	12,204	13,387	117,307	8.76	18
19	Laundry	3,813	4,267	33,986	7.96	19
20	Administrator	1,922	2,086	75,275	36.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,893	2,086	37,543	18.00	23
24	Clerical	4,681	5,066	43,918	8.67	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	3,508	3,790	76,031	20.06	31
32	Other Health C: SOCIAL WKR	3,303	3,477	71,701	20.62	32
33	Other(specify) <u>MARKETING</u>	430	451	10,852	24.06	33
34	TOTAL (lines 1 - 33)	158,915	172,396	\$ 2,390,950 *	\$ 13.87	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	155	\$ 9,506	1-3	35
36	Medical Director	96	9,600	9-3	36
37	Medical Records Consultant	76	5,130	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	96	4,905	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	2	130	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	54	3,616	11-3	44
45	Social Service Consultant	186	13,262	12-3	45
46	Other(specify) <u>ALZHEIMERS</u>	58	3,982	10-3	46
47	<u>PSYCHIATRIC</u>	96	13,500	10-3	47
48					48
49	TOTAL (lines 35 - 48)	819	\$ 63,631		49

**C. CONTRACT NURSES**

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



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

**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 - \$12344.40
- (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. \$ 6,239 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: \_\_\_\_\_
- (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.