FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 48504

Facility Name: AMBERWOOD CARE CENTRE, LLC

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

County: WINNEBAGO COUNTY

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MICHAEL C. BRAUN **Telephone Number:** (847) 583-0100 EXT: 126
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 01/01/2011 to 12/31/2011 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) MICHAEL C. BRAUN
(Title) CONTROLLER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

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 CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	143	52,195	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,350	527	5,843	11,720	8
9	SNF/PED					9
10	ICF	21,399	2,108	4,997	28,504	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,749	2,635	10,840	40,224	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.06%

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 [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 143 and days of care provided 4,594

Medicare Intermediary NATIONAL GOV'T SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	227,017	34,031	17,487	278,535		278,535		278,535			1
2	Food Purchase		250,549		250,549		250,549	(5,682)	244,867			2
3	Housekeeping	139,228	49,687		188,915		188,915		188,915			3
4	Laundry	37,115	25,381	3,857	66,353		66,353		66,353			4
5	Heat and Other Utilities			129,751	129,751		129,751		129,751			5
6	Maintenance	28,516	30,603	61,275	120,394		120,394		120,394			6
7	Other (specify):*			33,597	33,597		33,597		33,597			7
8	**TOTAL General Services**	431,876	390,251	245,967	1,068,094		1,068,094	(5,682)	1,062,412			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,977,659	143,741	192,007	2,313,407		2,313,407	91,960	2,405,367			10
10a	Therapy	3,904		1,023	4,927		4,927		4,927			10a
11	Activities	116,769	5,034	7,721	129,524		129,524		129,524			11
12	Social Services	41,614		5,927	47,541		47,541		47,541			12
13	CNA Training											13
14	Program Transportation			11,856	11,856		11,856		11,856			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,139,946	148,775	236,534	2,525,255		2,525,255	91,960	2,617,215			16
	C. General Administration											
17	Administrative	80,660			80,660		80,660	10,711	91,371			17
18	Directors Fees											18
19	Professional Services			391,329	391,329		391,329	(151,140)	240,189			19
20	Dues, Fees, Subscriptions & Promotions			182,571	182,571		182,571	(130,568)	52,003			20
21	Clerical & General Office Expenses	138,508	29,895	61,213	229,616		229,616	145,115	374,731			21
22	Employee Benefits & Payroll Taxes			495,651	495,651		495,651		495,651			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,321	5,321		5,321	10,786	16,107			24
25	Other Admin. Staff Transportation			8,251	8,251		8,251		8,251			25
26	Insurance-Prop.Liab.Malpractice			213,466	213,466		213,466	2,981	216,447			26
27	Other (specify):*			472,086	472,086		472,086	(472,086)				27
28	**TOTAL General Administration**	219,168	29,895	1,829,888	2,078,951		2,078,951	(584,201)	1,494,750			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,790,990	568,921	2,312,389	5,672,300		5,672,300	(497,923)	5,174,377			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: AMBERWOOD CARE CENTRE, LLC #48504 **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,031	
	REPAIRS & MAINTENANCE		8,456	
			0	17,487
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,857	
			0	3,857
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		45,899	
	ELECTRICITY		60,356	
	WATER		23,496	
	CABLE TV - LOBBY		0	
			0	129,751
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		20,475	
	PAINTING & DECORATING		3,122	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		21,999	
	ELEVATOR MAINTENANCE & REPAIR		5,820	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,900	
	FIRE SERVICE		5,959	
			0	
			0	
			0	
			0	61,275
7	**OTHER**			
	SCAVENGER		33,597	
	SECURITY SERVICE		0	
			0	
			0	33,597
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,000	18,000

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 CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	6,207	
	PHARMACY CONSULTANT	XVIII B 39-2	10,276	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B 47-2	12,000	
	RN CONSULTANT	XVIII B 38-2	154,449	
	ALZHEIMERS	XVIII B 46-2	9,075	
			0	192,007
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	1,023	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				1,023
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		4,643	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,078	
			0	7,721
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	5,927	
	SOCIAL WORKER	XVIII B 45-2	0	
				5,927
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC #48504 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		11,856	11,856
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	47,737	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	343,592	
			0	391,329
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	97,667	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	23,986	
	EMPLOYEE WANT ADS	XIX F	32,970	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	11,359	
	LICENSES & PERMITS	XIX F	1,732	
	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	8,900	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	4,961	
	PATIENT BACKGROUND CHECKS	XIX F	496	
				182,571
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		8,441	
	EQUIPMENT REPAIR & MAINTENANCE		3,007	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	19,624	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		65	
	TELEPHONE		26,358	
	MESSENGER SERVICE		3,718	
			0	61,213

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	208,663	
	UNEMPLOYMENT COMPENSATION	XIX D	120,866	
	WORKERS COMPENSATION INSURANC	XIX D	64,295	
	HOSPITALIZATION INSURANCE	XIX D	96,520	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,241	
	EMPLOYEE PHYSICAL EXAMS	XIX D	66	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	495,651
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,792	
	TRAVEL	XIX G	1,529	
				5,321
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,251	
				8,251
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		213,466	
				213,466
27	**OTHER**			
	BAD DEBTS	VI 24	472,086	
				472,086

GRAND TOTAL COLUMN 3 OTHER **2,312,389**

AMBERWOOD CARE CENTRE, LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	250,549
LESS SALES TAX	(5,682)
NET FOOD	244,867
TOTAL PATIENT CENSUS	40,224
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	120,672
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	120,672
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	120,672
NET FOOD	244,867
DIVIDE TOTAL MEALS/YEAR	120,672
COST PER MEAL	2.03
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC #48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			109,499	109,499		109,499	(38,153)	71,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,334	17,334		17,334	(10,075)	7,259			32
33	Real Estate Taxes			57,952	57,952		57,952		57,952			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(268,228)	31,772			34
35	Rent-Equipment & Vehicles			28,277	28,277		28,277	12,489	40,766			35
36	Other (specify):*											36
37	**TOTAL Ownership**			513,062	513,062		513,062	(303,967)	209,095			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		246,325	309,745	556,070		556,070		556,070			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,370	81,370		81,370		81,370			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		246,325	391,115	637,440		637,440		637,440			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,790,990	815,246	3,216,566	6,822,802		6,822,802	(801,890)	6,020,912			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 CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(64,028)	30		9
10	Interest and Other Investment Income	(10,075)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,682)	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	(19,624)	21		18
19	Entertainment	(97,667)	20		19
20	Contributions	(9,400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	14,811	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(472,086)	27		24
25	Fund Raising, Advertising and Promotional	(23,986)	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	(7,717)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (695,454)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(106,436)	PG 6-6C	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (106,436)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (801,890)		37

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

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

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

AMBERWOOD CARE CENTRE, LLC

ID# 48504

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	VACATION ACCRUAL		1	2
3	VACATION ACCRUAL		3	3
4	VACATION ACCRUAL		4	4
5	VACATION ACCRUAL		6	5
6	VACATION ACCRUAL		10	6
7	VACATION ACCRUAL		11	7
8	VACATION ACCRUAL		17	8
9	VACATION ACCRUAL		21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B CONSULTANT		19	11
12	MARKETING CONSULTANT	(5,717)	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**	(7,717)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,682)	0	0	0	0	0	0	0	0	0	0	(5,682)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,682)	0	0	0	0	0	0	0	0	0	0	(5,682)	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	0	0	0	91,960	0	0	0	0	0	0	0	91,960	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	91,960	0	0	0	0	0	0	0	91,960	16
	C. General Administration													
17	Administrative	0	0	10,711	0	0	0	0	0	0	0	0	10,711	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	7,094	0	72,163	1,479	(231,876)	0	0	0	0	0	0	(151,140)	19
20	Fees, Subscriptions & Promotions	(131,053)	0	112	34	339	0	0	0	0	0	0	(130,568)	20
21	Clerical & General Office Expenses	(19,624)	0	11,027	10,223	154,111	(10,622)	0	0	0	0	0	145,115	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	1,126	4,447	5,213	0	0	0	0	0	0	10,786	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	620	910	1,451	0	0	0	0	0	0	2,981	26
27	Other (specify):*	(472,086)	0	0	0	0	0	0	0	0	0	0	(472,086)	27
28	**TOTAL General Administration**	(615,669)	0	95,759	17,093	(70,762)	(10,622)	0	0	0	0	0	(584,201)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(621,351)	0	95,759	109,053	(70,762)	(10,622)	0	0	0	0	0	(497,923)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(64,028)	22,916	998	451	1,510	0	0	0	0	0	0	(38,153)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,075)	0	0	0	0	0	0	0	0	0	0	(10,075)	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	1,606	30,166	0	0	0	0	0	0	(268,228)	34
35	Rent-Equipment & Vehicles	0	0	8,502	2,956	1,031	0	0	0	0	0	0	12,489	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(74,103)	(277,084)	9,500	5,013	32,707	0	0	0	0	0	0	(303,967)	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)	(695,454)	(277,084)	105,259	114,066	(38,055)	(10,622)	0	0	0	0	0	(801,890)	45

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 300,000	AMBERWOOD HEALTH CARE CENTRE		$	$ (300,000)	1
2	V	30	DEPRECIATION - BLDG/IMP		" "		22,916	22,916	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			$ 22,916	$ * (277,084)	14

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES		$ 72,163	$ 72,163	15
16	V	20	DUES & SUBSCRIPTIONS		" "		112	112	16
17	V	21	CLERICAL		" "		11,027	11,027	17
18	V	24	TRAVEL		" "		1,126	1,126	18
19	V	26	INSURANCE		" "		620	620	19
20	V	35	RENT - EQPT & VEH		" "		8,502	8,502	20
21	V	30	DEPRECIATION		" "		998	998	21
22	V	17	ADMINISTRATIVE		" "		10,711	10,711	22
23	V	34	RENT		" "				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			$			$ 105,259	$ * 105,259	39

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARLYLE NURSING ASSOCIATES, LLC		$ 91,960	$ 91,960	15
16	V	19	PROFESSIONAL FEES		" "		1,479	1,479	16
17	V	20	DUES & SUBSCRIPTIONS		" "		34	34	17
18	V	21	CLERICAL		" "		10,223	10,223	18
19	V	24	TRAVEL		" "		4,447	4,447	19
20	V	26	INSURANCE		" "		910	910	20
21	V	30	DEPRECIATION		" "		451	451	21
22	V	34	RENT		" "		1,606	1,606	22
23	V	35	RENT - EQPT & VEH		" "		2,956	2,956	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			$			$ 114,066	$ * 114,066	39

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 232,801	THE KENSINGTON GROUP, LLC		$ 925	$ (231,876)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		339	339	16
17	V	21	CLERICAL		" "		154,111	154,111	17
18	V	24	TRAVEL		" "		5,213	5,213	18
19	V	26	INSURANCE		" "		1,451	1,451	19
20	V	30	DEPRECIATION		" "		1,510	1,510	20
21	V	34	RENT		" "		30,166	30,166	21
22	V	35	RENT - EQPT & VEH		" "		1,031	1,031	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			$ 232,801			$ 194,746	$ * (38,055)	39

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL	$ 19,194	YORK MANAGEMENT ASSOCIATES, LLC		$ 8,572	$ (10,622)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			$ 19,194			$ 8,572	$ * (10,622)	39

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ROCKTON GROUP LLC	100			YORK MANAGEMEI	MORTON GROVE	MANAGEMENT C	1
2					CARLYLE NURSING	MORTON GROVE	NURSING CONSUI	2
3					THE KENSINGTON C	MORTON GROVE	FINANCIAL SERV	3
4					CHESTERFIELD LLC	MORTON GROVE	MANAGEMENT C	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] 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 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	365,329	7	$ 655,412	$	40,224	$ 72,163	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	365,329	7	1,013		40,224	112	2
3	21	CLERICAL	PATIENT DAYS	365,329	7	100,148		40,224	11,027	3
4	24	TRAVEL	PATIENT DAYS	365,329	7	10,227		40,224	1,126	4
5	26	INSURANCE	PATIENT DAYS	365,329	7	5,635		40,224	620	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	365,329	7	77,221		40,224	8,502	6
7	30	DEPRECIATION	PATIENT DAYS	365,329	7	9,065		40,224	998	7
8	34	RENT	PATIENT DAYS	365,329	7	97,279		40,224	10,711	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					$ 956,000	$		$ 105,259	25

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] 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 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	10	NURSING	DIRECT COST	1	1	$ 91,960	$ 91,960	1	$ 91,960	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	546,424	11	20,088		40,224	1,479	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	546,424	11	463		40,224	34	3
4	21	CLERICAL	PATIENT DAYS	546,424	11	138,873		40,224	10,223	4
5	24	TRAVEL	PATIENT DAYS	546,424	11	60,405		40,224	4,447	5
6	26	INSURANCE	PATIENT DAYS	546,424	11	12,367		40,224	910	6
7	30	DEPRECIATION	PATIENT DAYS	546,424	11	6,120		40,224	451	7
8	34	RENT	PATIENT DAYS	546,424	11	21,816		40,224	1,606	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	546,424	11	40,152		40,224	2,956	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					$ 392,244	$ 91,960		$ 114,066	25

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] 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 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	546,424	11	$ 12,560	$	40,224	$ 925	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	546,424	11	4,608		40,224	339	2
3	21	CLERICAL	PATIENT DAYS	546,424	11	214,045		40,224	15,757	3
4	24	TRAVEL	PATIENT DAYS	546,424	11	70,816		40,224	5,213	4
5	26	INSURANCE	PATIENT DAYS	546,424	11	19,708		40,224	1,451	5
6	30	DEPRECIATION	PATIENT DAYS	546,424	11	20,511		40,224	1,510	6
7	34	RENT	PATIENT DAYS	546,424	11	409,787		40,224	30,166	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	546,424	11	14,000		40,224	1,031	8
9	21	CLERICAL	DIRECT COST	1	1	138,354	138,354	1	138,354	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					$ 904,389	$ 138,354		$ 194,746	25

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: YORK MANAGEMENT ASSOCIATES, 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 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	21	CLERICAL	DIRECT COST	1	1	$ 8,572	$ 8,572	1	$ 8,572	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,572	$ 8,572		$ 8,572	25

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	ALBANK		X	WORKING CAPITAL	DEMAND	12/06	1,200,000	1,250,000	DEMAND	PRIME +	15,576	6
7	MAXSOURCE		X	WORKING CAPITAL	DEMAND	12/08	100,000		DEMAND	VARIES	1,758	7
8												8
9	TOTAL Facility Related						$ 1,300,000	$ 1,250,000			$ 17,334	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,300,000	$ 1,250,000			$ 17,334	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

*** 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 CENTRE, LLC **#** 48504 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 55,553	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.)		$ 55,252	2
3. Under or (over) accrual (line 2 minus line 1).		$ (301)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 58,253	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.		$ 57,952	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	37,926	8
	2007	47,119	9
	2008	50,180	10
	2009	52,648	11
	2010	55,252	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 2009 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBERWOOD CARE CENTRE, LLC COUNTY WINNEBAGO COUNTY

FACILITY IDPH LICENSE NUMBER 48504

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-11-354-001	NURSING HOME	$ 55,252.00	$ 55,252.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,252.00	$ 55,252.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	39,171	1994	$ 171,000	1
2					2
3	TOTALS	39,171		$ 171,000	3

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLUSH STEEL DOOR WITH MISCO WIRE GLASS			2006	2,010	73	27.5	73		314	9
10	METAL DOOR WITH FULL MORTISE HINGE			2006	1,784	65	27.5	65		273	10
11	WHEEL CHAIR RAMPS			2006	2,650	96	27.5	96		406	11
12	DRYWALL FRAME; INSULATED METAL DOOR			2006	1,070	39	27.5	39		164	12
13	REMOVE & REPLACE 7 SECTIONS OF CONCRETE SIDEWALK			2006	1,950	70	27.5	70		293	13
14	REMOVE OLD & INSTALL NEW ALUMINUM SIGNS			2006	4,135	150	27.5	150		608	14
15	DOOR PROTECTIVE DEVICES ON 2 PASSENGER ELEVATORS			2004	2,300	83	27.5	83		328	15
16	PANELS, VALENCES, & BORDER - 2ND FLOOR			2007	11,346	1,135	10	1,135		4,160	16
17	TILES & GROUT - 2ND FLOOR			2007	8,622	314	27.5	314		1,071	17
18	TOILETS - 2ND FLOOR			2007	646	24	27.5	24		80	18
19	2 BARRIER FREE SHOWERS			2007	3,998	145	27.5	145		497	19
20	TILES - 2ND FLOOR			2007	939	34	27.5	34		111	20
21	BREAKING OUT CONCRETE AND INSTALL NEW DRAIN			2007	734	26	27.5	26		87	21
22	CUSTOM FORM PVC FRAME GUARDS - 2ND FLOOR			2007	3,845	140	27.5	140		454	22
23	INSULATED METAL DOOR & DRYWALL FRAMES			2008	27,604	1,004	27.5	1,004		2,844	23
24	EXIT SIGNS			2008	1,029	37	27.5	37		100	24
25	FIRE DOORS AND PARTS			2008	6,450	235	27.5	235		586	25
26	EXHAUST PIPING FOR INTAKE FANS			2008	4,314	157	27.5	157		405	26
27	CARPET			2008	1,600	194	5	160	(34)	667	27
28	INSTALLED 21 SMOKE DETECTORS			2008	5,000	182	27.5	182		470	28
29	CUBICLE CURTAINS			2008	3,530	406	5	353	(53)	1,412	29
30	LIGHT FIXTURES			2008	3,048	111	27.5	111		240	30
31	VINYL WALL COVERING			2008	1,831	211	5	183	(28)	610	31
32	LACE FLOORING - DINING AREAS			2008	2,897	334	5	290	(44)	966	32
33	KITCHEN AREA - REMODEL TO PLACE NEW EQUIPMENT			2008	41,327	1,503	27.5	1,503		3,256	33
34	SUPPLIES FOR KITCHEN REMODELING			2008	1,088	39	27.5	39		86	34
35	LIGHTING FOR KITCHEN			2008	702	26	27.5	26		53	35
36	PVC DRAIN PIPES FOR KITCHEN SINK			2008	1,015	37	27.5	37		77	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 CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOORS - ACTIVITY ROOM & CENTRAL NURSES STATION	2008	$ 7,206	$ 830	5	$ 720	$ (110)	$ 2,162	37
38	RUN ADDTL GAS & ELECTRIC LINES/REBUILD WALL								38
39	BEHIND FREEZER	2009	5,000	182	27.5	182		273	39
40	INSTALL 2 BACKFLOW DEVICES, GENERATOR AND RUN								40
41	UNDERGROUND POWER WIRE	2009	19,591	712	27.5	712		772	41
42	SECURE ELEVATOR FOR DIRECT ACCESS TO ALZHEIMERS								42
43	UNIT	2010	4,431	161	27.5	161		128	43
44	WIRED IN SPRINKLER FLOW & TAMPER SWITCH TO FIRE								44
45	PANEL	2010	2,505	91	27.5	91		42	45
46	INSULATED METAL DOORS & DRYWALL FRAMES	2010	2,507	91	27.5	91		19	46
47	WALK IN COOLER	2010	10,171	370	27.5	370		46	47
48	BALANCE PAYMENT FOR WALK IN COOLER	2011	3,534	123	27.5	128	5		48
49	CABINER HEATERS	2011	52,397	397	27.5	318	(79)		49
50	DOORS & DOOR FRAMES	2011	10,748	49	27.5	33	(16)		50
51	SIDEWALK LANDING	2011	1,930	3	27.5	6	3		51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61	*******RELATED PARTY - AMBERWOOD HEALTH CARE CENTRE, INC *****								61
62	PAINT & PUT BORDER FOR ROOMS 216 THRU 264	2009	54,300	1,974	27.5	1,974		3,949	62
63	REMOVE & INSTALL APPROX. 50 DOORS AND PAINT THE	2009	55,050	2,001	27.5	2,001		4,004	63
64	CONVERT MED ROOM TO NURSES STATION - REMOVE &								64
65	INSTALL WALL COVERINGS, NEW CEILING, NEW VCT								65
66	TILES & CARPETING, & INSTALL PARTITION WALLS	2009	32,000	3,200	27.5	3,200		4,267	66
67	DEMOLISH & RENOVATE ALZHEIMERS WING/ACTIVITY								67
68	RM/& NURSES STATION - INSTALLED WALLS & WINDOWS								68
69	CEILINGS, REMOVED BORDERS & PAINTED WALLS,								69
70	TOTAL (lines 4 thru 69)		$ 408,834	$ 17,054		$ 16,698	$ (356)	$ 36,280	70

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 408,834	$ 17,054		$ 16,698	$ (356)	$ 36,280	1
2	INSTALL OUTLETS & WIRING AS NEEDED.	2009	17,600	1,490	10	1,490		2,980	2
3	INSTALL DRYWALL & CAULK AREAS IN THE BASEMENT								3
4	PER LIFE SAFETY CODE	2009	10,000	364	27.5	364		728	4
5	ALZHEIMERS UNIT - INSTALL NEW DOOR, REPAIR SHOWER								5
6	ROOM, STRIP & PAINT ALL RES. ROOMS IN THE WING	2009	12,800	465	27.5	465		930	6
7	STRIP & PAINT FRONT LOBBY/VESTIBULE DOORS & FRA	2009	10,000	364	27.5	364		728	7
8	REPAIR & PAINT - PUBLIC RESTROOM, FAMILY ROOM								8
9	COVE BASE, 2ND FLOOR EMPLYEE RESTROOM	2009	10,450	478	27.5	478		956	9
10	REPAIR & PAINT/PUT BORDER FOR RMS 140 THRU 170 &								10
11	DOOR REPLACEMENT	2009	33,700	3,370	10	3,370		4,493	11
12	REPAIR & PAINT/PUT BORDER FOR RMS 140 THRU 170 &								12
13	DOOR REPLACEMENT - BALANCE PAYMENT	2010	7,130	713	10	713		713	13
14	NEW FIRE SPRINKLER SYSTEM-INSTALL WET PIPE SYS.								14
15	WITH A REDUCED BACKFLOW, TIE INTO SPRINKLER								15
16	PIPING IN BASEMENT & EXTEND TO 2 FLOORS COVERING								16
17	49500 SQ FOOT TOTAL	2010	106,572	3,875	27.5	3,875		3,391	17
18	INSTALL DRYWALL AROUND LAUNDRY CHUTE, ALZHEIMERS								18
19	DINING RM ON THE WESTSIDE, EXAM ROOM, SOUTH								19
20	SHOWER ROOM, SOILED UTILITY ROOM & SHOWER								20
21	ROOMS	2010	21,250	772	27.5	772		612	21
22	INSULATED RESIDENT SMOKE ROOM & PANTRY	2010	11,400	415	27.5	415		86	22
23	PAINT WALLS & CEILINGS - AREA NEAR DINING RM								23
24	ENTRANCE, AND CORRIDORS THROUGHOUT FACILITY	2010	4,050	405	10	405			24
25	LIFE SAFETY REPAIRS	2011	29,950	1,044	27.5	1,044			25
26	REPAIR & PAINT 16 RESIDENT ROOMS	2011	5,250	525	10	438	(87)		26
27	REMOVE WALL PAPER & PAINT ROOMS	2011	9,600	960	10	560	(400)		27
28	WALL TREATMENTS & PAINT - DINING ROOMS	2011	19,750	1,975	10	988	(987)		28
29									29
30			ADJ TO SL	(1,474)			1,474		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 718,336	$ 32,795		$ 32,439	$ (356)	$ 51,897	34

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 334,629	$ 29,160	$ 33,460	$ 4,300	3-15 YRS	$ 113,190	71
72	Current Year Purchases	70,460	70,460	2,488	(67,972)	3-15 YRS	2,488	72
73	Fully Depreciated Assets	7,500					7,500	73
74	RELATED PARTY		2,959	2,959				74
75	TOTALS	$ 412,589	$ 102,579	$ 38,907	$ (63,672)		$ 123,178	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,301,925	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,374	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 71,346	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (64,028)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 175,075	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 CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 21,295 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2005 TOYOTA CAMRY	$ 479.00	$ 6,982	17
18					18
19					19
20					20
21	TOTAL		$ 479.00	$ 6,982	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.

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	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	$		$ 149,087	$		$ 149,087	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,653			13,653	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			147,005			147,005	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				139,572		139,572	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					106,753		106,753	13
14	TOTAL			$		$ 309,745	$ 246,325		$ 556,070	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.

STATE OF ILLINOIS

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,839	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 386,126)	3,013,289		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,516		6
7	Other Prepaid Expenses	3,113		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,140,757	$	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	267,482		15
16	Equipment, at Historical Cost	405,088		16
17	Accumulated Depreciation (book methods)	(414,541)		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)**	$ 258,029	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,398,786	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,135,710	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,499		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,761		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,253		32
33	Accrued Interest Payable	17,214		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	RENT PAYABLE	1,918,125		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,315,562	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,349,219		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)**	$ 5,349,219	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,664,781	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,265,995)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,398,786	$	48

***(See instructions.)**

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,072,542)	1
2	Restatements (describe):		2
3	ROUNDING ADJ	(6)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,072,548)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(193,447)	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)**	$ (193,447)	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)**	$ (6,265,995)	24 *

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,618,980	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,618,980	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***	10,075	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,075	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	300	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 300	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,629,355	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,068,094	31
32	Health Care	2,525,255	32
33	General Administration	2,078,951	33
	B. Capital Expense		
34	Ownership	513,062	34
	C. Ancillary Expense		
35	Special Cost Centers	556,070	35
36	Provider Participation Fee	81,370	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,822,802	40
41	**Income before Income Taxes (line 30 minus line 40)****	(193,447)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (193,447)	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 CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,941	2,126	$ 117,645	$ 55.34	1
2	Assistant Director of Nursing	2,396	2,613	88,153	33.74	2
3	Registered Nurses	12,303	13,153	362,049	27.53	3
4	Licensed Practical Nurses	23,945	25,576	608,049	23.77	4
5	CNAs & Orderlies	75,827	80,812	768,970	9.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	410	432	3,904	9.04	8
9	Activity Director	2,086	2,217	35,262	15.91	9
10	Activity Assistants	9,031	9,640	81,507	8.46	10
11	Social Service Workers	1,989	2,086	41,614	19.95	11
12	Dietician					12
13	Food Service Supervisor	3,705	3,944	53,814	13.64	13
14	Head Cook	2,976	3,269	29,488	9.02	14
15	Cook Helpers/Assistants	14,881	16,006	143,715	8.98	15
16	Dishwashers					16
17	Maintenance Workers	1,961	2,077	28,516	13.73	17
18	Housekeepers	14,250	15,337	139,228	9.08	18
19	Laundry	4,041	4,472	37,115	8.30	19
20	Administrator	1,973	2,166	80,660	37.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,023	9,721	138,508	14.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,161	32,793	15.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,818	197,808	$ 2,790,990 *	$ 14.11	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,031	1-3	35
36	Medical Director	O	18,000	9-3	36
37	Medical Records Consultant	N	6,207	10-3	37
38	Nurse Consultant	T	154,449	10-3	38
39	Pharmacist Consultant	H	10,276	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		1,023	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,078	11-3	44
45	Social Service Consultant	E	5,927	12-3	45
46	Other(specify) ALZHEIMERS	S	9,075	10-3	46
47	PSYCHIATRIC		12,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 229,066		49

C. CONTRACT NURSES

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

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JULIE LOGAN	ADMINISTRATOR		$ 80,660
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,660

B. Administrative - Other

Description		Amount
WITTINGHAM MNGMT ASSOC, LLC	MANAGEMENT F	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)		$
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		391,329
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 391,329

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,295
Unemployment Compensation Insurance	120,866
FICA Taxes	208,663
Employee Health Insurance	96,520
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	5,241
EMPLOYEE PHYSICAL EXAMS	66
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 495,651

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	32,970
Health Care Worker Background Check	4,961
(Indicate # of checks performed 496)	
Patient Background Checks 49	496
TRUST/FRANCHISE/CONTRIB/ETC	9,400
MARKETING/ADV/PROMO	121,653
LICENSES/DUES/SUBSCRIPTIONS	13,091
MGMT CO ALLOC	485
TRUST/FRANCHISE/CONTRIB/ETC	(9,400)
Less: Public Relations Expense	(97,667)
Non-allowable advertising	(23,986)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,003

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,529
RELATED PARTY	10,786
Seminar Expense	
	3,792
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,107

**See instructions.

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number AMBERWOOD CARE CENTRE, LLC # 48504 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 - $ 13365**

(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. $ **2,101** 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. $ **81,370**
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.