FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0052191

Facility Name: AMBERWOOD CARE CENTRE

Address: 2313 N ROCKTON AVE (Number) ROCKFORD (City) 61103 (Zip Code)

County: WINNEBAGO

Telephone Number: (815) 964-2220 **Fax #** (815) 965-7722

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2013

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: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 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) SHERRY GILLIHAN
(Title) ADMINISTRATOR

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	143	Skilled (SNF)	143	52,195	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	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			4,535	4,535	8
9	SNF/PED					9
10	ICF	28,484	3,497	5,725	37,706	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,484	3,497	10,260	42,241	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.93%

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 01/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2013 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 4,535

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	235,021	1,116	9,266	245,403		245,403		245,403			1
2	Food Purchase		319,836		319,836		319,836	(6,221)	313,615			2
3	Housekeeping	178,082	24,100		202,182		202,182		202,182			3
4	Laundry	60,387	2,830	8,577	71,794		71,794		71,794			4
5	Heat and Other Utilities			146,592	146,592		146,592		146,592			5
6	Maintenance		68,800	69,107	137,907		137,907		137,907			6
7	Other (specify):*			32,834	32,834		32,834		32,834			7
8	**TOTAL General Services**	473,490	416,682	266,376	1,156,548		1,156,548	(6,221)	1,150,327			8
	B. Health Care and Programs											
9	Medical Director			18,500	18,500		18,500		18,500			9
10	Nursing and Medical Records	2,296,521	221,957	58,272	2,576,750		2,576,750		2,576,750			10
10a	Therapy	80,292			80,292		80,292		80,292			10a
11	Activities	143,538	5,143		148,681		148,681		148,681			11
12	Social Services	51,594			51,594		51,594		51,594			12
13	CNA Training											13
14	Program Transportation			18,297	18,297		18,297		18,297			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,571,945	227,100	95,069	2,894,114		2,894,114		2,894,114			16
	C. General Administration											
17	Administrative	123,838		329,938	453,776		453,776		453,776			17
18	Directors Fees											18
19	Professional Services			209,215	209,215		209,215	(9,886)	199,329			19
20	Dues, Fees, Subscriptions & Promotions			47,538	47,538		47,538	(26,370)	21,168			20
21	Clerical & General Office Expenses	152,779	40,656	24,644	218,079		218,079	(45,785)	172,294			21
22	Employee Benefits & Payroll Taxes			540,451	540,451		540,451		540,451			22
23	Inservice Training & Education			4,442	4,442		4,442		4,442			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			6,747	6,747		6,747		6,747			25
26	Insurance-Prop.Liab.Malpractice			175,316	175,316		175,316		175,316			26
27	Other (specify):*			168,000	168,000		168,000	(168,000)				27
28	**TOTAL General Administration**	276,617	40,656	1,506,291	1,823,564		1,823,564	(250,041)	1,573,523			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,322,052	684,438	1,867,736	5,874,226		5,874,226	(256,262)	5,617,964			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 **#0052191** **Report Period Beginning: 01/01/2014** **Ending: 12/31/2014**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,266	
	REPAIRS & MAINTENANCE		0	
				9,266
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		8,577	
				8,577
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		56,734	
	ELECTRICITY		57,587	
	WATER		20,726	
	CABLE TV - LOBBY		11,545	
				146,592
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		21,864	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12,471	
	ELEVATOR MAINTENANCE & REPAIR		11,306	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		10,593	
	FIRE SERVICE		12,873	
				69,107
7	**OTHER**			
	SCAVENGER		32,105	
	SECURITY SERVICE		729	
				32,834
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,500	18,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		6,756	
	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	2,188	
	PHARMACY CONSULTANT	XVIII B 39-2	1,912	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	13,000	
	RN CONSULTANT	XVIII B 38-2	6,176	
	ALZHEIMERS		5,321	
	PROGRAM		22,919	58,272
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AMBERWOOD CARE CENTRE **#0052191** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		18,297	
				18,297
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	329,938	329,938
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	61,226	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	147,989	
				209,215
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	22,727	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	13,215	
	LICENSES & PERMITS	XIX F	4,501	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	497	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,146	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	992	
	PATIENT BACKGROUND CHECKS	XIX F	2,460	
				47,538
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,137	
	EQUIPMENT REPAIR & MAINTENANCE		36	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	5,534	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,300	
	MESSENGER SERVICE		1,637	
				24,644

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	250,634	
	UNEMPLOYMENT COMPENSATION	XIX D	103,086	
	WORKERS COMPENSATION INSURANC	XIX D	105,324	
	HOSPITALIZATION INSURANCE	XIX D	79,307	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,869	
	EMPLOYEE PHYSICAL EXAMS	XIX D	231	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
				540,451
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,442	
				4,442
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,747	
				6,747
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		175,316	
				175,316
27	**OTHER**			
	BAD DEBTS	VI 24	168,000	
				168,000

GRAND TOTAL COLUMN 3 OTHER **1,867,736**

AMBERWOOD CARE CENTRE
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	319,836
LESS SALES TAX	(6,221)
NET FOOD	313,615
TOTAL PATIENT CENSUS	42,241
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	126,723
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	126,723
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	126,723
NET FOOD	313,615
DIVIDE TOTAL MEALS/YEAR	126,723
COST PER MEAL	2.47
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number AMBERWOOD CARE CENTRE #0052191 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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			40,264	40,264		40,264	(18,851)	21,413			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			62,258	62,258		62,258		62,258			33
34	Rent-Facility & Grounds			240,000	240,000		240,000		240,000			34
35	Rent-Equipment & Vehicles			46,385	46,385		46,385		46,385			35
36	Other (specify):*											36
37	**TOTAL Ownership**			388,907	388,907		388,907	(18,851)	370,056			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		68,644	743,957	812,601		812,601		812,601			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			328,561	328,561		328,561		328,561			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		68,644	1,072,518	1,141,162		1,141,162		1,141,162			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,322,052	753,082	3,329,161	7,404,295		7,404,295	(275,113)	7,129,182			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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Refer-ence	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	(18,851)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,221)	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	(5,534)	21		18
19	Entertainment		20		19
20	Contributions	(3,146)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(9,886)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(168,000)	27		24
25	Fund Raising, Advertising and Promotional	(22,727)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(497)	20		28
29	Other-Attach Schedule	(40,251)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (275,113)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (275,113)		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

ID# 0052191

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (40,251)	21	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				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**	(40,251)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(6,221)	0	0	0	0	0	0	0	0	0	0	(6,221)	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**	(6,221)	0	0	0	0	0	0	0	0	0	0	(6,221)	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	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,886)	0	0	0	0	0	0	0	0	0	0	(9,886)	19
20	Fees, Subscriptions & Promotions	(26,370)	0	0	0	0	0	0	0	0	0	0	(26,370)	20
21	Clerical & General Office Expenses	(45,785)	0	0	0	0	0	0	0	0	0	0	(45,785)	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(168,000)	0	0	0	0	0	0	0	0	0	0	(168,000)	27
28	**TOTAL General Administration**	(250,041)	0	0	0	0	0	0	0	0	0	0	(250,041)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(256,262)	0	0	0	0	0	0	0	0	0	0	(256,262)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(18,851)	0	0	0	0	0	0	0	0	0	0	(18,851)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,851)	0	0	0	0	0	0	0	0	0	0	(18,851)	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)**	(275,113)	0	0	0	0	0	0	0	0	0	0	(275,113)	45

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
KE RIPSTEIN	95	NA		NA		
YAEL RIPSTEIN	5					

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 [X] 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	6		$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	N/A								$		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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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					$	$		$	25

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 55,320	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.)		$ 58,078	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,758	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 59,500	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.		$ 62,258	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012	56,753	11
2013	58,078	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 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBERWOOD CARE CENTRE COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0052191

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-11-354-001	NURSING HOME	$ 58,077.62	$ 58,077.62
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,077.62	$ 58,077.62

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [X] (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. [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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	100 AMP 3 PHASE SWITCH			2013	6,040	155	39	155		310	9
10	STOREROOM LEVERS, DOOR RESTRICTOR, STAIRWELL LOCK			2013	12,806	328	39	328		496	10
11	WIRING FOR PHONE LINES			2013	14,040	360	39	360		600	11
12	CHILLER MOTORS, COMPRESSOR, PUMP & MOTOR			2013	30,549	783	39	783		1,122	12
13	COURTYARD PATIO & LANDSCAPING			2013	54,611	3,641	15	3,641		5,461	13
14	REPAVE PARKING LOTS			2013	22,861	1,524	15	1,524		2,286	14
15	CARPET TILES			2013	3,905	100	39	100		125	15
16	BOILER & BACKFLOW PREVENTER			2013	49,086	1,259	39	1,259		1,469	16
17	DRYWALL REPAIR & PAINT			2013	2,020	52	39	52		78	17
18	SHOWER ROOM WORK			2013	5,850	150	39	150		263	18
19	KITCHEN REPAIRS			2013	2,500	64	39	64		107	19
20	DOORS & FRAMES			2013	23,000	590	39	590		983	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

*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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	AMBERWOD HEALTHCARE CENTER INC		$	$		$	$	$	37
38	ARCHITECTURE	2013	40,000	1,026	39	1,026		1,538	38
39	EXTERIOR CONCRETE WORK	2013	10,228	262	39	262		393	39
40	EXTERIORSTEEL RAILINGS & HANDRAILS	2013	12,472	320	39	320		480	40
41	HVAC SYSTEM	2013	133,093	3,412	39	3,412		5,118	41
42	FIRE SPRINKLER	2013	4,480	115	39	115		172	42
43	DEMO WALLS CEILINGS FLOORS WINDOWS DOORS IN								43
44	OLD - FRONT ENTRY,LOBBY/RECEPTION,VISITOR SEATING,								44
45	ADMINISTRATOR'S OFFICE,PT ROOM, CONFERENCE ROOM,								45
46	DON OFFICE, NURSE MANAGER'S OFFICE,MDS/SERVICE OFFICE,								46
47	BUSINESS OFC,RESIDENT LOUNGE,FRONT CORRIDOR AR	2013	6,700	172	39	172		258	47
48									48
49	INTERIOR CONSTRUCTION - BUILD WALLS,								49
50	STRUCTURAL BARING BEAMS, DOORS & WINDOWS,								50
51	PAINT, WALLPAPER,RUBBER SHOE BASE -								51
52	NEW- FRONT ENTRY VESTIBULE,LOBBY/RECEPTION,								52
53	ADMINISTRATOR'S OFFICE,ADMISSION'S OFFICE, RESIDENT								53
54	LOUNGE,2 STORAGE ROOMS,PT ROOM, CONFERENCE ROOM,								54
55	MDS COORDINATOR'S OFFICE, DON OFFICE, SOCIAL								55
56	SERVICE OFC, MDS/MARKETING OFC, FRONT CORRIDOR	2013	112,032	2,873	39	2,873		4,309	56
57									57
58	DOOR HARDWARE								58
59	FRONT ENTRY VESTIBULE,LOBBY/RECEPTION,								59
60	ADMINISTRATOR'S OFFICE,ADMISSION'S OFFICE, RESIDENT								60
61	LOUNGE,2 STORAGE ROOMS,PT ROOM, CONFERENCE ROOM,								61
62	MDS COORDINATOR'S OFFICE, DON OFFICE, SOCIAL								62
63	SERVICE OFC, MDS/MARKETING OFC, FRONT CORRIDOR	2013	5,531	142	39	142		213	63
64									64
65	EXTERIOR SIDING,PILLARS,TRIM,SHUTTERS	2013	40,590	1,041	39	1,041		1,561	65
66	RECEPTION CABINETS,COLUMNS,GRANITE COUNTER	2013	18,260	468	39	468		702	66
67	PLUMBING DRAIN WATER SUPPLY LINES	2013	16,400	420	39	420		630	67
68	ELECTRIC FIREPLACE	2013	8,209	210	39	210		315	68
69	ELECTRICAL CONDUIT,WIRE OUTLETS,SWITCHES,FIXTU	2013	38,000	974	39	974		1,461	69
70	TOTAL (lines 4 thru 69)		$ 673,263	$ 20,441		$ 20,441	$	$ 30,450	70

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 673,263	$ 20,441		$ 20,441	$	$ 30,450	1
2	FLOORING INSTALLATION-TILE, CARPET								2
3	FRONT ENTRY VESTIBULE,LOBBY/RECEPTION,								3
4	ADMINISTRATOR'S OFFICE,ADMISSION'S OFFICE, RESIDENT								4
5	LOUNGE,2 STORAGE ROOMS,PT ROOM, CONFERENCE ROOM,								5
6	MDS COORDINATOR'S OFFICE, DON OFFICE, SOCIAL								6
7	SERVICE OFC, MDS/MARKETING OFC, FRONT CORRIDOR	2013	32,747	840	39	840		1,260	7
8									8
9	INTERIOR DESIGN								9
10	FRONT ENTRY VESTIBULE,LOBBY/RECEPTION,								10
11	ADMINISTRATOR'S OFFICE,ADMISSION'S OFFICE, RESIDENT								11
12	LOUNGE,2 STORAGE ROOMS,PT ROOM, CONFERENCE ROOM,								12
13	MDS COORDINATOR'S OFFICE, DON OFFICE, SOCIAL								13
14	SERVICE OFC, MDS/MARKETING OFC, FRONT CORRIDOR	2013	5,000	128	39	128		192	14
15									15
16	MATERIAL-CARPET,TILE,WINDOW TRTMTS,BASE,WALLCOVERING								16
17	FRONT ENTRY VESTIBULE,LOBBY/RECEPTION,								17
18	ADMINISTRATOR'S OFFICE,ADMISSION'S OFFICE, RESIDENT								18
19	LOUNGE,2 STORAGE ROOMS,PT ROOM, CONFERENCE ROOM,								19
20	MDS COORDINATOR'S OFFICE, DON OFFICE, SOCIAL								20
21	SERVICE OFC, MDS/MARKETING OFC, FRONT CORRIDOR	2013	33,520	859	39	859		1,289	21
22									22
23									23
24	2ND FLOOR SHOWER ROOM-REMOVE FLOORS & WALLS								24
25	INSTALL DUROCK CEMENT BOARD, CERAMIC WALL &								25
26	FLOOR TILE	2014	5,766	136	39	136		136	26
27									27
28	2ND FLOOR HALLWAY-REMOVE ASBESTOS TILE- REPAIR								28
29	CONCRETE FLOOR, INSTALL TILE	2014	47,438	912	39	912		912	29
30									30
31	1ST FLOOR HALLWAY-REMOVE ASBESTOS TILE- REPAIR								31
32	CONCRETE FLOOR, INSTALL TILE	2014							32
33									33
34	TOTAL (lines 1 thru 33)		$ 797,734	$ 23,316		$ 23,316	$	$ 34,239	34

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 12B, Carried Forward		$ 797,734	$ 23,316		$ 23,316	$	$ 34,239	1
2	DINING ROOM- REMOVE-CENTER ISLAND, COLUMN WALL,								2
3	CROWN MOLDING, BASE BOARD, FLOOR, CEILING,								3
4	DOOR TRIM, INSTALL-TILE FLOOR, 2 CENTER COLUMNS								4
5	ELECTRIC FOR TV OUTLET, INSULATION, DROP CEILING								5
6	LIGHT FIXTURES, MOLDING, PAINT	2014	18,735	480	27.5	480		480	6
7									7
8	FLOORING FOR 1ST & 2ND FLOOR HALLWAYS	2014	18,588	376	27.5	376		376	8
9	COMMERCIAL FIRE ALARM SYSTEM UPGRADE	2014	11,077	213	27.5	213		213	9
10	2ND FLOOR STAIRWELL LOCKING SYSTEM	2014	3,400	73	27.5	73		73	10
11	2ND FLOOR AIR CONDITIONING UNITS RESIDENT ROOMS	2014	87,386	1,681	27.5	1,681		1,681	11
12	1ST FLOOR FLOORING	2014	19,688	378	27.5	378		378	12
13	CEMENT WALKWAY WORK IN GARDEN	2014	5,466	17	27.5	17		17	13
14	1ST FLOOR SHOWER WALLS, FLOORING, DOORS	2014	12,046	145	27.5	145		145	14
15	KITCHEN CLOSET, FRONT OFFICE NEW DRYWALL PAINT	2014	1,875	17	27.5	17		17	15
16	CEILING & DRYWALL REPAIR, KITCHEN, BREAKROOM, 1ST FLOOR HALL CLOSET, CONFERENCE ROOM								16
17		2014	11,045	16	27.5	16		16	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	TOTAL (lines 1 thru 33)		$ 987,040	$ 26,712		$ 26,712	$	$ 37,635	34

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 43,902	$ 5,376	$ 4,390	$ (986)		$ 8,780	71
72	Current Year Purchases	35,730	21,438	3,573	(17,865)		3,573	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 79,632	$ 26,814	$ 7,963	$ (18,851)		$ 12,353	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)	$ 1,066,672	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,526	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,675	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,851)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 49,988	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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: AMBERWOOD CARE CENTRE LLC
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. [X] 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:		143	01/01/2013	$ 240,000	25		3
4	Additions							4
5								5
6								6
7	TOTAL		143		$ 240,000 **			7

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

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 01/01/2013
    Ending 12/31/37

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	01/01/2015	$ 276,000
13.	01/01/2016	$ 300,000
14.	01/01/2017	$ 300,000

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: $ 27,061 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			$	$ 19,324	17
18					18
19					19
20					20
21	TOTAL		$	$ 19,324	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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 236,209	$		$ 236,209	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			47,510			47,510	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			293,904			293,904	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			166,334			166,334	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): SUPPLIES, MISC	39-2					68,644		68,644	12
13	Other (specify):									13
14	TOTAL			$		$ 743,957	$ 68,644		$ 812,601	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 CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 453,229	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 296,356)	2,906,165		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	174,195		6
7	Other Prepaid Expenses	30,706		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,564,295	$	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	469,777		15
16	Equipment, at Historical Cost	79,632		16
17	Accumulated Depreciation (book methods)	(69,645)		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)**	$ 479,764	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,044,059	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,059,323	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,048		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,822		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,211,693	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,211,693	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,832,366	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,044,059	$	48

***(See instructions.)**

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,071,966	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,071,966	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	760,400	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)**	$ 760,400	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,832,366	24	*

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,983,849	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,983,849	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	76,672	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 76,672	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	18	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)**	$ 18	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	426	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 426	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,060,965	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,156,548	31
32	Health Care	2,894,114	32
33	General Administration	1,823,564	33
	B. Capital Expense		
34	Ownership	388,907	34
	C. Ancillary Expense		
35	Special Cost Centers	812,601	35
36	Provider Participation Fee	328,561	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(103,730)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,300,565	40
41	**Income before Income Taxes (line 30 minus line 40)****	760,400	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 760,400	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,089,017	44
45	Private Pay - Net Inpatient Revenue	543,838	45
46	Medicare - Net Inpatient Revenue	2,136,195	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	1,214,799	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,983,849	49

**TAX RETURN NOT COMPLETED

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2,030	2,146	$ 87,915	$ 40.97	1
2	Assistant Director of Nursing	3,839	4,109	142,459	34.67	2
3	Registered Nurses	14,609	15,268	419,185	27.46	3
4	Licensed Practical Nurses	25,410	27,071	681,389	25.17	4
5	CNAs & Orderlies	85,541	91,070	930,434	10.22	5
6	CNA Trainees					6
7	Licensed Therapist	3,807	4,251	80,292	18.89	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,532	2,796	40,382	14.44	9
10	Activity Assistants	11,269	12,028	103,156	8.58	10
11	Social Service Workers	1,993	2,086	51,594	24.73	11
12	Dietician					12
13	Food Service Supervisor	3,757	4,664	66,362	14.23	13
14	Head Cook	7,504	8,137	75,686	9.30	14
15	Cook Helpers/Assistants	10,456	10,835	92,973	8.58	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	18,717	20,394	178,082	8.73	18
19	Laundry	6,292	6,773	60,387	8.92	19
20	Administrator	1,937	2,086	123,838	59.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,199	11,172	152,779	13.68	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	2,025	2,086	35,139	16.85	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,917	226,972	$ 3,322,052 *	$ 14.64	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	$ 9,266	1-3	35
36	Medical Director	O	18,500	9-3	36
37	Medical Records Consultant	N	2,188	10-3	37
38	Nurse Consultant	T	6,176	10-3	38
39	Pharmacist Consultant	H	1,912	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		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	ALZHEIMERS CONSULTANT		5,321	10-3	47
48	PROGRAM CONSULTANT		22,919	10-3	48
49	TOTAL (lines 35 - 48)		$ 66,282		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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHERRY GILLIHAN	ADMINISTRATOR	0	$ 123,838
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 123,838

B. Administrative - Other

Description	Amount
	$
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		209,215
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 209,215

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,324
Unemployment Compensation Insurance	103,086
FICA Taxes	250,634
Employee Health Insurance	79,307
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,869
EMPLOYEE PHYSICAL EXAMS	231
TOTAL (agree to Schedule V, line 22, col.8)	$ 540,451

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,310
Advertising: Employee Recruitment	0
Health Care Worker Background Check	992
(Indicate # of checks performed)	
Patient Background Checks	2,460
TRUST/FRANCHISE/CONTRIB/ETC	3,146
MARKETING/ADV/PROMO	23,224
LICENSES/DUES/SUBSCRIPTIONS	14,406
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(3,146)
Less: Public Relations Expense	(0)
Non-allowable advertising	(22,727)
Yellow page advertising	(497)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,168

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			$		$	$	$	$	$	$	$	$	$
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 # 0052191 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. **ICLTC $5,843**

(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. $ 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? **X** YES 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. $ **328,561**
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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.