FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 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 #** (847) 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 01/01/2015 to 12/31/2015 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) SAMANTHA BANEY
(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: 01/01/2015 Ending: 12/31/2015

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			4,054	4,054	8
9	SNF/PED					9
10	ICF	27,506	3,173	5,625	36,304	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,506	3,173	9,679	40,358	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.32%

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 4,054

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	221,664	5,389	9,141	236,194		236,194		236,194			1
2	Food Purchase		281,375		281,375		281,375	(2,388)	278,987			2
3	Housekeeping	213,408	28,670		242,078		242,078		242,078			3
4	Laundry	83,459	3,326	13,009	99,794		99,794		99,794			4
5	Heat and Other Utilities			152,086	152,086		152,086		152,086			5
6	Maintenance	14,775	67,343	63,281	145,399		145,399		145,399			6
7	Other (specify):*			23,437	23,437		23,437		23,437			7
8	**TOTAL General Services**	533,306	386,103	260,954	1,180,363		1,180,363	(2,388)	1,177,975			8
	B. Health Care and Programs											
9	Medical Director			19,000	19,000		19,000		19,000			9
10	Nursing and Medical Records	2,052,639	155,327	62,285	2,270,251		2,270,251	(25,939)	2,244,312			10
10a	Therapy	187,224			187,224		187,224		187,224			10a
11	Activities	161,777	4,090		165,867		165,867		165,867			11
12	Social Services	51,734			51,734		51,734		51,734			12
13	CNA Training											13
14	Program Transportation			18,155	18,155		18,155		18,155			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,453,374	159,417	99,440	2,712,231		2,712,231	(25,939)	2,686,292			16
	C. General Administration											
17	Administrative	131,029		310,313	441,342		441,342		441,342			17
18	Directors Fees											18
19	Professional Services			187,959	187,959		187,959		187,959			19
20	Dues, Fees, Subscriptions & Promotions			112,090	112,090		112,090	(81,317)	30,773			20
21	Clerical & General Office Expenses	162,285	39,678	47,707	249,670		249,670	(21,665)	228,005			21
22	Employee Benefits & Payroll Taxes			441,081	441,081		441,081		441,081			22
23	Inservice Training & Education			13,654	13,654		13,654		13,654			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			8,288	8,288		8,288		8,288			25
26	Insurance-Prop.Liab.Malpractice			253,111	253,111		253,111		253,111			26
27	Other (specify):*			1,100,058	1,100,058		1,100,058	(1,100,058)				27
28	**TOTAL General Administration**	293,314	39,678	2,474,261	2,807,253		2,807,253	(1,203,040)	1,604,213			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,279,994	585,198	2,834,655	6,699,847		6,699,847	(1,231,367)	5,468,480			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: 01/01/2015** **Ending: 12/31/2015**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,141	
	REPAIRS & MAINTENANCE		0	
				9,141
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		13,009	
				13,009
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		47,365	
	ELECTRICITY		67,070	
	WATER		26,433	
	CABLE TV - LOBBY		11,218	
				152,086
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		16,872	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,486	
	ELEVATOR MAINTENANCE & REPAIR		9,288	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,605	
	FIRE SERVICE		5,030	
	CONTRACTED BUILDING MAINTENANCE		16,000	
				63,281
7	**OTHER**			
	SCAVENGER		23,437	
	SECURITY SERVICE		0	

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		1,061	
	PURCHASED SERVICES		8,880	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,457	
	PHARMACY CONSULTANT	XVIII B 39-2	10,329	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	11,000	
	RN CONSULTANT	XVIII B 38-2	3,970	
	PROGRAM CONSULTANT		16,417	
	ALZHEIMERS CONSULTANT		8,171	62,285
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	

				23,437
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	19,000	19,000

				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AMBERWOOD CARE CENTRE **#0052191** **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		18,155	
				18,155
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	310,313	310,313
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	67,624	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	120,335	
				187,959
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	75,010	
	EMPLOYEE WANT ADS	XIX F	200	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	23,680	
	LICENSES & PERMITS	XIX F	2,886	
	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	6,307	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	957	
	PATIENT BACKGROUND CHECKS	XIX F	3,050	
				112,090
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,827	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	21,665	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,399	

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	250,610	
	UNEMPLOYMENT COMPENSATION	XIX D	76,718	
	WORKERS COMPENSATION INSURANC	XIX D	94,649	
	HOSPITALIZATION INSURANCE	XIX D	5,717	
	EMPLOYEE BENEFITS - OTHER	XIX D	13,222	
	EMPLOYEE PHYSICAL EXAMS	XIX D	165	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
				441,081
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		13,654	
				13,654
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,288	
				8,288
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		253,111	
				253,111
27	**OTHER**			
	BAD DEBTS	VI 24	1,100,058	
				1,100,058

GRAND TOTAL COLUMN 3 OTHER **2,834,655**

MESSENGER SERVICE	816	
		47,707

AMBERWOOD CARE CENTRE
SCHEDULES
12/31/2015

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

TOTAL FOOD PURCHASE	281,375
LESS SALES TAX	(2,388)
NET FOOD	278,987
TOTAL PATIENT CENSUS	40,358
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	121,074
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	121,074
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	121,074
NET FOOD	278,987
DIVIDE TOTAL MEALS/YEAR	121,074
COST PER MEAL	2.30
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

AMBERWOOD PROPERTY
EDUCATION & SEMINARS
12/31/15

	SPONSOR OF SEMINAR	SEMINAR PURPOSE	PERSONNEL ATTENDING	DEPARTMENT	LOC	COST OF SEMINAR
JAN	SWEDISH AMERICAN	CPR	NURSING STAFF	NURSING		10
JAN	ST. ANTHONY COLLEGE OF NURSING	TUITION	SAMANTHA B.	ADMINISTRATOR		4,844
APRIL	AMERICAN EXPRESS	HIN SEMINARS	SHERRY HEAD	ADMINISTRATOR		129
APRIL	ROCK VALLEY COLLEGE	TUITION	SAMANTHA B.	ADMINISTRATOR		1,066
APRIL	SWEDISH AMERICAN	CPR	NURSING STAFF	NURSING		10
APRIL	ST. ANTHONY COLLEGE OF NURSING	TUITION	SAMANTHA B.	ADMINISTRATOR		2,176
MAY	CROSS COUNTRY EDUCATION	MDS MED DOCUMENTATION	TRAVAS TUCKER	MDS COORDINATOR		199
JUNE	IL COUNCIL ON LONG TERM CARE	STATE OPERATIONS SEMINAR	KEN R. SEERRY H.	OWNER, ADMIN.		300
JULY	SWEDISH AMERICAN HEALTH	CPR	NURSING STAFF	NURSING		43
AUG	ST. ANTHONY COLLEGE OF NURSING	TUITION	SAMANTHA B.	ADMINISTRATOR		2,535
SEP	SWEDISH AMERICAN HEALTH	CPR	NURSING STAFF	NURSING		43
OCT	AMERICAN EXPRESS					966
NOV	WENDY L. EDMONDS	BOOKS	WENDY	NURSING		286
NOV	CONTINENTAL TESTING	IL ADMIN APP FEE	SAMANTHA B.	ADMINISTRATOR		278
DEC	ROCK VALLEY COLLEGE	TUITION	SAMANTHA B.	ADMINISTRATOR		770
						13,654

TRANSPORTATION - STAFF
2015 COST REPORT

NAME	TITLE /DEPT	PURPOSE	AMOUNT
CHARLOTTE WYANT	DON	MILEAGE	87
CHANDRA RINEHART	ACTIVITIES DIRECTOR	MILEAGE	124
THE IL TOLLWAY	MAINTENANCE/ACTIVITIES		90
ALPINE BODY SHOP	QAN/MARKETING	CAR REPAIR	1,363
AMBERWOOD CARE		VEHICLE STICKER	284
AMBERWOOD CARE	MDS COORD.	GAS	40
KEN FLORIANT	OWNER	MILEAGE	78
NICHOLAS MORGAN	ADMISSIONS	MILEAGE	500
JERRY VILLELA	MAINTENANCE	MILEAGE	1,164
AMERICAN EXPRESS		MILEAGE	2,263
SHERRY GILLIHAN	ADMINISTRATOR	MILEAGE	599
ANNE JOHNSON	QAN/MARKETING/ADMISSION	MILEAGE	1,566
KIMBERLY MUTIMER	OFFICE CLERICAL	MILEAGE	130

TOTAL			8,288
			========

Facility Name & ID Number AMBERWOOD CARE CENTRE #0052191 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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			29,058	29,058		29,058	10,367	39,425			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			316	316		316	(316)				32
33	Real Estate Taxes			87,763	87,763		87,763		87,763			33
34	Rent-Facility & Grounds			276,000	276,000		276,000		276,000			34
35	Rent-Equipment & Vehicles			42,930	42,930		42,930		42,930			35
36	Other (specify):*											36
37	**TOTAL Ownership**			436,067	436,067		436,067	10,051	446,118			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,822	518,461	688,283		688,283		688,283			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			339,433	339,433		339,433		339,433			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		169,822	857,894	1,027,716		1,027,716		1,027,716			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,279,994	755,020	4,128,616	8,163,630		8,163,630	(1,221,316)	6,942,314			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: 01/01/2015 Ending: 12/31/2015

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	10,367	30		9
10	Interest and Other Investment Income	(316)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,388)	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	(21,665)	21		18
19	Entertainment		20		19
20	Contributions	(6,307)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(4,580)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,100,058)	27		24
25	Fund Raising, Advertising and Promotional	(75,010)	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	(25,939)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,225,896)		$	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))**	$ (1,225,896)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

AMBERWOOD CARE CENTRE

ID# **0052191**

Report Period Beginning: **01/01/2015**

Ending: **12/31/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (25,939)	10	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**	(25,939)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	(2,388)	0	0	0	0	0	0	0	0	0	0	(2,388)	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**	(2,388)	0	0	0	0	0	0	0	0	0	0	(2,388)	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	(25,939)	0	0	0	0	0	0	0	0	0	0	(25,939)	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**	(25,939)	0	0	0	0	0	0	0	0	0	0	(25,939)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(81,317)	0	0	0	0	0	0	0	0	0	0	(81,317)	20
21	Clerical & General Office Expenses	(21,665)	0	0	0	0	0	0	0	0	0	0	(21,665)	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):*	(1,100,058)	0	0	0	0	0	0	0	0	0	0	(1,100,058)	27
28	**TOTAL General Administration**	(1,203,040)	0	0	0	0	0	0	0	0	0	0	(1,203,040)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,231,367)	0	0	0	0	0	0	0	0	0	0	(1,231,367)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	10,367	0	0	0	0	0	0	0	0	0	0	10,367	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(316)	0	0	0	0	0	0	0	0	0	0	(316)	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**	10,051	0	0	0	0	0	0	0	0	0	0	10,051	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,221,316)	0	0	0	0	0	0	0	0	0	0	(1,221,316)	45

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			$			$	$	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: 01/01/2015 Ending: 12/31/2015

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	NA							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: 01/01/2015 Ending: 12/31/2015

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	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: 01/01/2015 Ending: 2/31/2015

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: 01/01/2015 Ending: 12/31/2015

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	PRIVATE BANK		X	WORKING CAPITAL				100,000		3.2500	316	6
7												7
8												8
9	TOTAL Facility Related						$	$ 100,000			$ 316	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 100,000			$ 316	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: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 59,500	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.)		$ 72,863	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,363	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 74,400	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.		$ 87,763	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011		9
2012	56,753	10
2013	58,078	11
2014	72,863	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 2014 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-11-354-001	NURSING HOME	$ 72,863.32	$ 72,863.32
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,863.32	$ 72,863.32

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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		465	9
10	STOREROOM LEVERS, DOOR RESTRICTOR, STAIRWELL LOCK			2013	12,806	328	39	328		824	10
11	WIRING FOR PHONE LINES			2013	14,040	360	39	360		960	11
12	CHILLER MOTORS, COMPRESSOR, PUMP & MOTOR			2013	30,549	860	39	860		1,982	12
13	COURTYARD PATIO & LANDSCAPING			2013	54,611	3,674	15	3,674		9,135	13
14	REPAVE PARKING LOTS			2013	22,861	1,291	15	1,291		3,577	14
15	CARPET TILES			2013	3,905	100	39	100		225	15
16	BOILER & BACKFLOW PREVENTER			2013	49,086	1,259	39	1,259		2,728	16
17	DRYWALL REPAIR & PAINT			2013	2,020	52	39	52		130	17
18	SHOWER ROOM WORK			2013	5,850	150	39	150		413	18
19	KITCHEN REPAIRS			2013	2,500	64	39	64		171	19
20	DOORS & FRAMES			2013	23,000	590	39	590		1,573	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: 01/01/2015 Ending: 12/31/2015

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		39	1,026	1,026	2,564	38
39	EXTERIOR CONCRETE WORK	2013	10,228		39	262	262	655	39
40	EXTERIORSTEEL RAILINGS & HANDRAILS	2013	12,472		39	320	320	800	40
41	HVAC SYSTEM	2013	133,093		39	3,412	3,412	8,530	41
42	FIRE SPRINKLER	2013	4,480		39	115	115	287	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		39	172	172	430	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		39	2,873	2,873	7,182	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		39	142	142	355	63
64									64
65	EXTERIOR SIDING,PILLARS,TRIM,SHUTTERS	2013	40,590		39	1,041	1,041	2,602	65
66	RECEPTION CABINETS,COLUMNS,GRANITE COUNTER	2013	18,260		39	468	468	1,170	66
67	PLUMBING DRAIN WATER SUPPLY LINES	2013	16,400		39	420	420	1,050	67
68	ELECTRIC FIREPLACE	2013	8,209		39	210	210	525	68
69	ELECTRICAL CONDUIT,WIRE OUTLETS,SWITCHES,FIXTU	2013	38,000		39	974	974	2,435	69
70	TOTAL (lines 4 thru 69)		$ 673,263	$ 8,883		$ 20,318	$ 11,435	$ 50,768	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: 01/01/2015 Ending: 12/31/2015

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	$ 8,883		$ 20,318	$ 11,435	$ 50,768	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		39	840	840	2,100	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		39	128	128	320	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		39	859	859	2,148	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		272	26
27									27
28	2ND FLOOR HALLWAY-REMOVE ASBESTOS TILE- REPAIR								28
29	CONCRETE FLOOR, INSTALL TILE	2014	47,438	912	39	912		1,824	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	$ 9,931		$ 23,193	$ 13,262	$ 57,432	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: 01/01/2015 Ending: 12/31/2015

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	$ 9,931		$ 23,193	$ 13,262	$ 57,432	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		960	6
7									7
8	FLOORING FOR 1ST & 2ND FLOOR HALLWAYS	2014	18,588	476	27.5	476		852	8
9	COMMERCIAL FIRE ALARM SYSTEM UPGRADE	2014	11,077	284	27.5	284		497	9
10	2ND FLOOR STAIRWELL LOCKING SYSTEM	2014	3,400	87	27.5	87		160	10
11	2ND FLOOR AIR CONDITIONING UNITS RESIDENT ROOMS	2014	87,386	2,205	27.5	2,205		3,886	11
12	1ST FLOOR FLOORING	2014	19,688	709	27.5	709		1,087	12
13	CEMENT WALKWAY WORK IN GARDEN	2014	5,466	199	27.5	199		216	13
14	1ST FLOOR SHOWER WALLS, FLOORING, DOORS	2014	12,046	438	27.5	438		583	14
15	KITCHEN CLOSET, FRONT OFFICE NEW DRYWALL PAINT	2014	1,875	68	27.5	68		85	15
16	CEILING & DRYWALL REPAIR, KITCHEN, BREAKROOM, 1ST FLOOR HALL CLOSET, CONFERENCE ROOM								16
17		2014	11,045	402	27.5	402		418	17
18	CARPETING ALZHEIMER'S UNIT	2015	9,401	176	27.5	176		176	18
19	CHILLER BARREL AND EXPANSION VALVE ASSEMBLY	2015	23,665	402	27.5	402		402	19
20	ROOMS 220 & 262 REMOVE & REINSTALL DRYWALL & PA	2015	3,716	75	27.5	75		75	20
21	2ND FLOOR SHOWER ROOM 1,2,& 3 REMOVE & INSTALL DRYWALL & CERMANIC TILE & PLUMBING								21
22		2015	16,695	276	27.5	276		276	22
23	ROOMS 158, 164 & 218 & ACCOUNTING OFFICE REMOVE & REINSTALL DRYWALL & PAINT								23
24		2015	6,960	126	27.5	126		126	24
25	2ND FLOOR NORTH-REMOVE CARPET & TILE REPAIR CONCRETE INSTALL TILE, BASEBOARD, REPAIR WALLS								25
26		2015	26,000	452	27.5	452		452	26
27	KITCHEN CEILING, FLOORING REPAIR, INSULATION, TIL	2015	8,568	151	27.5	151		151	27
28	TILE & SUPPLIES FOR 2ND FLOOR SHOWER	2015	3,476	75	27.5	75		75	28
29	ROOMS 172, 278, 217 REPAIR, PAINT WALLS & CEILING	2015	14,229	251	27.5	251		251	29
30	TOILET & GRANITE TOPS	2015	885	25	27.5	25		25	30
31	CONVERT SMOKE ROOM TO RESIDENT ROOMS 1ST FLOO	2015	9,789	176	27.5	176		176	31
32	1ST FLOOR DINING ROOM REMOVE WALLPAPER PATCH	2015	4,236	75	27.5	75		75	32
33	1ST FLOOR CONFERENCE REPAIR PATCH PAINT CEILING	2015	5,885	100	27.5	100		100	33
34	TOTAL (lines 1 thru 33)		$ 1,120,545	$ 17,639		$ 30,901	$ 13,262	$ 68,536	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: 01/01/2015 Ending: 12/31/2015

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 12C, Carried Forward		$ 1,120,545	$ 17,639		$ 30,901	$ 13,262	$ 68,536	1
2	RESIDENT ROOMS 158,148,152,103 REPAIR WATER DAMAG	2015	4,411	75	27.5	75		75	2
3	DIETARY OFFICE/SHOWER ROOM REPAIR PAINT WALLS	2015	1,512	25	27.5	25		25	3
4	IST FLOOR HALLWAYS, DINING ROOM INSTALL INSULTA	2015	7,835	151	27.5	151		151	4
5	REPAIR WATER DAMAGE LOBBY CEILING	2015	2,430	50	27.5	50		50	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	TOTAL (lines 1 thru 33)		$ 1,136,733	$ 17,940		$ 31,202	$ 13,262	$ 68,837	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: 01/01/2015 Ending: 12/31/2015

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	$ 79,632	$ 9,556	$ 7,963	$ (1,593)	10 YRS	$ 20,316	71
72	Current Year Purchases	2,604	1,562	260	(1,302)	10 YRS	260	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 82,236	$ 11,118	$ 8,223	$ (2,895)		$ 20,576	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)	$ 1,218,969	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,058	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 39,425	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,367	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 89,413	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: 01/01/2015 Ending: 12/31/2015

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	$ 276,000	25		3
4	Additions							4
5								5
6								6
7	TOTAL		143		$ 276,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. NA
   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 01/01/2013
    Ending 12/31/2037

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

	Fiscal Year Ending	Annual Rent
12.	01/01/2016	$ 300,000
13.	01/01/2017	$ 300,000
14.	01/01/2018	$ 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: $ 25,282 Description: (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			$	$ 17,648	17
18					18
19					19
20					20
21	TOTAL		$	$ 17,648	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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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		$		$ 205,899	$		$ 205,899	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				24,999			24,999	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				231,449			231,449	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					164,699		164,699	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): SUPPLIES, LAB, XRAY						56,114	5,123		61,237	13
14	TOTAL				$		$ 518,461	$ 169,822		$ 688,283	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 **#** 0052191 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2015 **(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	$ 58,967	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,319,278		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,072		6
7	Other Prepaid Expenses	29,206		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,545,523	$	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	620,482		15
16	Equipment, at Historical Cost	81,820		16
17	Accumulated Depreciation (book methods)	(98,703)		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)**	$ 603,599	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,149,122	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,523,281	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	76,800		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,525		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE PRIOR OWNER	987,307		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,770,313	$	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)**	$ 2,770,313	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,378,809	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,149,122	$	48

***(See instructions.)**

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,832,369	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,832,369	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(453,560)	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)**	$ (453,560)	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)**	$ 1,378,809	24 *

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 7,688,179	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,688,179	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,119	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 97,119	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***	1,634	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,634	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)**	$ 7,786,932	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,180,363	31
32	Health Care	2,712,231	32
33	General Administration	2,807,253	33
	B. Capital Expense		
34	Ownership	436,067	34
	C. Ancillary Expense		
35	Special Cost Centers	688,283	35
36	Provider Participation Fee	339,433	36
	D. Other Expenses (specify):		
37	PRIOR PERIOD ADJ	76,662	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,240,292	40
41	**Income before Income Taxes (line 30 minus line 40)****	(453,360)	41
42	**Income Taxes**	(200)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (453,560)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,020,744	44
45	Private Pay - Net Inpatient Revenue	532,833	45
46	Medicare - Net Inpatient Revenue	1,869,146	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	1,265,456	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,688,179	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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: 01/01/2015 Ending: 12/31/2015

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	1,744	1,792	$ 52,496	$ 29.29	1
2	Assistant Director of Nursing	3,605	3,820	97,343	25.48	2
3	Registered Nurses	15,700	16,473	391,148	23.74	3
4	Licensed Practical Nurses	22,001	22,664	543,372	23.98	4
5	CNAs & Orderlies	99,992	104,189	929,380	8.92	5
6	CNA Trainees					6
7	Licensed Therapist			187,224		7
8	Rehab/Therapy Aides					8
9	Activity Director	2,464	2,536	38,424	15.15	9
10	Activity Assistants	16,114	15,757	123,353	7.83	10
11	Social Service Workers	1,496	1,600	51,734	32.33	11
12	Dietician					12
13	Food Service Supervisor	4,070	4,180	53,538	12.81	13
14	Head Cook	9,227	9,745	77,796	7.98	14
15	Cook Helpers/Assistants	11,945	12,344	90,330	7.32	15
16	Dishwashers					16
17	Maintenance Workers	1,278	1,294	14,775	11.42	17
18	Housekeepers	24,082	24,907	213,408	8.57	18
19	Laundry	9,161	9,522	83,459	8.76	19
20	Administrator	2,720	2,880	131,029	45.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,427	14,108	162,285	11.50	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	5,042	5,206	38,900	7.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	244,068	253,017	$ 3,279,994 *	$ 12.96	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	$ 9,141	1-3	35
36	Medical Director	O	19,000	9-3	36
37	Medical Records Consultant	N	2,457	10-3	37
38	Nurse Consultant	T	3,970	10-3	38
39	Pharmacist Consultant	H	10,329	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					47
48					48
49	TOTAL (lines 35 - 48)		$ 44,897		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAMANTHA BANEY	ADMINISTRATOR	0	$ 32,307
SHERRY GILLIHAN	ADMINISTRATOR	0	98,722
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,029

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 310,313
TOTAL (agree to Schedule V, line 17, col. 3)	$ 310,313
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		187,959
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 187,959

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,649
Unemployment Compensation Insurance	76,718
FICA Taxes	250,610
Employee Health Insurance	5,717
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	13,222
EMPLOYEE PHYSICAL EXAMS	165
TOTAL (agree to Schedule V, line 22, col.8)	$ 441,081

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	$ 1,990
Advertising: Employee Recruitment	200
Health Care Worker Background Check	957
(Indicate # of checks performed)	
Patient Background Checks	3,050
TRUST/FRANCHISE/CONTRIB/ETC	6,307
MARKETING/ADV/PROMO	75,010
LICENSES/DUES/SUBSCRIPTIONS	24,576
TRUST/FRANCHISE/CONTRIB/ETC	(6,307)
Less: Public Relations Expense	(0)
Non-allowable advertising	(75,010)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,773

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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 $14,718**

(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? _____ 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. $ **14,793** 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 _____ 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. $ **339,433**
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.

AMBERWOOD PROPERTY
PROFESSIONAL FEES
2015

PROFESSIONAL SERVICE	DESCRIPTION	AMOUNT
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	25,545
SEE ATTACHED	LEGAL	38,838
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTANT	1,621
RICHARD PEELO	MEDICARE	2,500
GERTRUDE JEWELL	CONSULTING	1,098
SUSAN MCWHERTER	ADMIN. CONSULTANT	1,576
LITWILLER CONSULTING	CONSULTING	75
RICHTER & ASSOCIATES	DATA PROCESSING	49,082
WESCOM SOLUTIONS	DATA PROCESSING	14,556
EVAULT	DATA PROCESSING	720
IT REBATE	DATA PROCESSING	-1,941
PAYCHEX	DATA PROCESSING	11,844
EXPERIAN HEALTH	DATA PROCESSING	46
ROCKFORD CHAMBER	DATA PROCESSING	1,075
HEALTH DATA SYSTEM	DATA PROCESSING	4,544
SINGER NETWORKS	DATA PROCESSING	35,515
PASSPORT HEALTH	DATA PROCESSING	615
IIT/SOURCETECH	DATA PROCESSING	650

	TOTAL	**187,958**
		=========

AMBERWOOD PROPERTY
LEGAL FEES
12/31/2015

INVOICE DATE	FIRM NAME	AMOUNT
01/09/2015	DANIEL MAHER LAW OFFICES	300
01/09/2015	DANIEL MAHER LAW OFFICES	60
02/05/2015	DANIEL MAHER LAW OFFICES	300
02/05/2015	DANIEL MAHER LAW OFFICES	80
03/07/2015	DANIEL MAHER LAW OFFICES	60
03/07/2015	DANIEL MAHER LAW OFFICES	400
03/07/2015	DANIEL MAHER LAW OFFICES	40
04/10/2015	DANIEL MAHER LAW OFFICES	360
04/10/2015	DANIEL MAHER LAW OFFICES	40
07/08/2015	DANIEL MAHER LAW OFFICES	180
05/08/2015	DANIEL MAHER LAW OFFICES	80
04/10/2015	DANIEL MAHER LAW OFFICES	300
05/08/2015	DANIEL MAHER LAW OFFICES	160
12/31/2015	G. JEWELL	4,000
03/27/2015	HIPP LAW OFFICE	35
02/27/2015	HIPP LAW OFFICE	7
04/30/2015	HIPP LAW OFFICE	605
05/31/2015	HIPP LAW OFFICE	4
07/31/2015	HIPP LAW OFFICE	4
08/31/2015	HIPP LAW OFFICE	4
09/30/2015	HIPP LAW OFFICE	4
12/31/2015	HIPP LAW OFFICE	4
06/04/2015	SCOTT & KRAUS	527
06/10/2015	FRANKS,GERKIN & MCKENNA	289
02/28/2015	FRANKS,GERKIN & MCKENNA	350
03/31/2015	FRANKS,GERKIN & MCKENNA	350
03/31/2015	FRANKS,GERKIN & MCKENNA	250
03/31/2015	FRANKS,GERKIN & MCKENNA	250
03/31/2015	FRANKS,GERKIN & MCKENNA	250

03/31/2015	FRANKS,GERKIN & MCKENNA	250
03/31/2015	FRANKS,GERKIN & MCKENNA	350
03/31/2015	FRANKS,GERKIN & MCKENNA	250
03/31/2015	FRANKS,GERKIN & MCKENNA	250
03/31/2015	FRANKS,GERKIN & MCKENNA	15
03/31/2015	FRANKS,GERKIN & MCKENNA	60
03/31/2015	FRANKS,GERKIN & MCKENNA	250
04/17/2015	FRANKS,GERKIN & MCKENNA	20
04/17/2015	FRANKS,GERKIN & MCKENNA	68
04/30/2015	FRANKS,GERKIN & MCKENNA	350
04/30/2015	FRANKS,GERKIN & MCKENNA	103
04/30/2015	FRANKS,GERKIN & MCKENNA	285
05/05/2015	FRANKS,GERKIN & MCKENNA	20
05/31/2015	FRANKS,GERKIN & MCKENNA	250
05/27/2015	FRANKS,GERKIN & MCKENNA	6
06/04/2015	FRANKS,GERKIN & MCKENNA	423
06/30/2015	FRANKS,GERKIN & MCKENNA	39
06/30/2015	FRANKS,GERKIN & MCKENNA	110
07/10/2015	FRANKS,GERKIN & MCKENNA	120
07/20/2015	FRANKS,GERKIN & MCKENNA	10
07/31/2015	FRANKS,GERKIN & MCKENNA	358
08/10/2015	FRANKS,GERKIN & MCKENNA	161
07/27/2015	FRANKS,GERKIN & MCKENNA	139
07/18/2015	FRANKS,GERKIN & MCKENNA	1
07/28/2015	FRANKS,GERKIN & MCKENNA	20
1/31/2015	STONE MCGUIRE	1,000
2/28/2015	STONE MCGUIRE	1,000
3/31/2015	STONE MCGUIRE	1,000
4/30/2015	STONE MCGUIRE	1,000
5/31/2015	STONE MCGUIRE	1,000
6/30/2015	STONE MCGUIRE	1,000
7/31/2015	STONE MCGUIRE	1,000
8/31/2015	STONE MCGUIRE	1,000
10/31/2015	STONE MCGUIRE	4,000
11/30/2015	STONE MCGUIRE	2,000
1/31/2015	ASHMAN & STEIN	830
1/31/2015	ASHMAN & STEIN	198
2/28/2015	ASHMAN & STEIN	1,264

03/02/2015	ASHMAN & STEIN	474
3/31/2015	ASHMAN & STEIN	198
3/31/2015	ASHMAN & STEIN	2,044
5/31/2015	ASHMAN & STEIN	988
6/30/2015	ASHMAN & STEIN	1,067
8/31/2015	ASHMAN & STEIN	474
9/4/2015	ASHMAN & STEIN	869
9/4/2015	ASHMAN & STEIN	988
9/4/2015	ASHMAN & STEIN	750
11/2/2015	ASHMAN & STEIN	750
12/7/2015	ASHMAN & STEIN	751
		38,838

DESCRIPTION
OF SERVICES

GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING

RECORDING MEMO OF JUDGMENT
COLLECTION FEES
SETTLEMENT , COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
AMENDMENT DOCUMENTS TO EXTEND MATURITY DATE OF CREDIT
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES

COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
GENERAL MATTERS
COLLECTION FEES
RECORDING MEMO OF JUDGMENT
SERVING INITIAL SUMMONS
COLLECTION FEES
SERVING INITIAL SUMMONS
GENERAL MATTERS
RECORDING MEMO OF JUDGMENT
COLLECTION FEES
FEES ON DP
GENERAL MATTERS
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
COLLECTION FEES
GENERAL MATTERS
COURT COSTS
COURT COSTS
SERVING ALIAS SUMMONS
RECORDING MEMO OF JUDGMENT
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
COMPLIANCE LEGAL
GENERAL COUNSELING
WASTE CONTRACT ISSUES
GENERAL COUNSELING

GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
GENERAL COUNSELING
EMPLOYEE MATTERS
PHARMERICA
PHARMERICA
PHARMERICA