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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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	141	Skilled (SNF)	141	51,606	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	141	TOTALS	141	51,606	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,135	5,135	8
9	SNF/PED					9
10	ICF	32,308	4,715	1,928	38,951	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,308	4,715	7,063	44,086	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.43%

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 141 and days of care provided 5,135

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	37,610	8,780	511,551	557,941		557,941		557,941			1
2	Food Purchase		41,691		41,691		41,691	(468)	41,223			2
3	Housekeeping	207,375	50,012	24,000	281,387		281,387	1,628	283,015			3
4	Laundry	93,403	23,796	5,060	122,259		122,259		122,259			4
5	Heat and Other Utilities			149,752	149,752		149,752	1,731	151,483			5
6	Maintenance	51,898	61,741	83,225	196,864		196,864	1,634	198,498			6
7	Other (specify):*			16,507	16,507		16,507		16,507			7
8	TOTAL General Services	390,286	186,020	790,095	1,366,401		1,366,401	4,525	1,370,926			8
	B. Health Care and Programs											
9	Medical Director			38,500	38,500		38,500		38,500			9
10	Nursing and Medical Records	2,455,197	237,698	48,018	2,740,913		2,740,913	(7,180)	2,733,733			10
10a	Therapy	132,483			132,483		132,483		132,483			10a
11	Activities	171,494	11,380		182,874		182,874		182,874			11
12	Social Services	53,228			53,228		53,228		53,228			12
13	CNA Training											13
14	Program Transportation			8,021	8,021		8,021		8,021			14
15	Other (specify):*							8,455	8,455			15
16	TOTAL Health Care and Programs	2,812,402	249,078	94,539	3,156,019		3,156,019	1,275	3,157,294			16
	C. General Administration											
17	Administrative	106,922		378,263	485,185		485,185	77,424	562,609			17
18	Directors Fees											18
19	Professional Services			288,936	288,936		288,936	159,636	448,572			19
20	Dues, Fees, Subscriptions & Promotions			119,379	119,379		119,379	(67,348)	52,031			20
21	Clerical & General Office Expenses	232,367	42,886	148,956	424,209		424,209	(68,271)	355,938			21
22	Employee Benefits & Payroll Taxes			613,303	613,303		613,303		613,303			22
23	Inservice Training & Education			10,030	10,030		10,030		10,030			23
24	Travel and Seminar							493	493			24
25	Other Admin. Staff Transportation			8,502	8,502		8,502	1,038	9,540			25
26	Insurance-Prop.Liab.Malpractice			225,097	225,097		225,097	3,682	228,779			26
27	Other (specify):*			168,000	168,000		168,000	(142,704)	25,296			27
28	TOTAL General Administration	339,289	42,886	1,960,466	2,342,641		2,342,641	(36,050)	2,306,591			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,541,977	477,984	2,845,100	6,865,061		6,865,061	(30,250)	6,834,811			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: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	1,446	
	REPAIRS & MAINTENANCE		24,173	
	CONTRACTED DIETARY SERVICES		485,932	511,551
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICES		24,000	
				24,000
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,060	
				5,060
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		29,199	
	ELECTRICITY		61,390	
	WATER		42,740	
	CABLE TV - LOBBY		16,423	
				149,752
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		19,345	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		16,039	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		22,599	
	ELEVATOR MAINTENANCE & REPAIR		11,714	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		6,050	
	FIRE SERVICE		7,478	
				83,225
7	**OTHER**			
	SCAVENGER		16,507	
	SECURITY SERVICE		0	
				16,507
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	38,500	38,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		113	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	500	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,789	
	PHARMACY CONSULTANT	XVIII B 39-2	8,798	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	13,967	
	PSYCHIATRIC	XVIII B __-2	11,000	
	RN CONSULTANT	XVIII B 38-2	2,330	
	ALZHEIMERS CONSULTANT		7,623	
	DENTAL SERVICES		1,898	48,018
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	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AMBERWOOD CARE CENTRE **#0052191** **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		8,021	
				8,021
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	378,263	378,263
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	106,859	
	ADMINISTRATIVE CONSULTANTS	XIX C	76,375	
	PROFESSIONAL FEES	XIX C	105,702	
				288,936
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	59,010	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	27,196	
	LICENSES & PERMITS	XIX F	14,505	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	12,558	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	725	
	PATIENT BACKGROUND CHECKS	XIX F	5,385	
				119,379
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,681	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		105,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	17,059	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,859	
	MESSENGER SERVICE		357	
				148,956

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	274,136	
	UNEMPLOYMENT COMPENSATION	XIX D	59,990	
	WORKERS COMPENSATION INSURANCI	XIX D	122,323	
	HOSPITALIZATION INSURANCE	XIX D	130,864	
	EMPLOYEE BENEFITS - OTHER	XIX D	21,307	
	EMPLOYEE PHYSICAL EXAMS	XIX D	360	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	4,323	
				613,303
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,030	
				10,030
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,502	
				8,502
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		225,097	
				225,097
27	**OTHER**			
	BAD DEBTS	VI 24	168,000	
				168,000

GRAND TOTAL COLUMN 3 OTHER **2,845,100**

AMBERWOOD CARE CENTRE
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	41,691
LESS SALES TAX	(468)
NET FOOD	41,223
TOTAL PATIENT CENSUS	44,086
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	132,258
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	51,606
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	132,258
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	132,258
NET FOOD	41,223
DIVIDE TOTAL MEALS/YEAR	132,258
COST PER MEAL	0.31
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number AMBERWOOD CARE CENTRE #0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			64,187	64,187		64,187	(9,161)	55,026			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,629	4,629		4,629	780	5,409			32
33	Real Estate Taxes			101,826	101,826		101,826		101,826			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	14,194	314,194			34
35	Rent-Equipment & Vehicles			23,985	23,985		23,985	8,009	31,994			35
36	Other (specify):*											36
37	TOTAL Ownership			494,627	494,627		494,627	13,822	508,449			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		238,236	729,694	967,930		967,930		967,930			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			362,714	362,714		362,714		362,714			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		238,236	1,092,408	1,330,644		1,330,644		1,330,644			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,541,977	716,220	4,432,135	8,690,332		8,690,332	(16,428)	8,673,904			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: 01/01/2016 Ending: 12/31/2016

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	(13,097)	30		9
10	Interest and Other Investment Income	(681)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(468)	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	(17,059)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(4,783)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(168,000)	27		24
25	Fund Raising, Advertising and Promotional	(59,010)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(12,558)	20		28
29	Other-Attach Schedule SEE PG 5A	(55,126)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (330,782)		$	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)	314,354		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 314,354		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (16,428)		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: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (55,061)	21	1
2	MARKETING TRAVEL	(65)	25	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**	(55,126)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(468)	0	0	0	0	0	0	0	0	0	0	(468)	2
3	Housekeeping	0	0	1,628	0	0	0	0	0	0	0	0	1,628	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,731	0	0	0	0	0	0	0	0	1,731	5
6	Maintenance	0	0	1,634	0	0	0	0	0	0	0	0	1,634	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(468)	0	4,993	0	0	0	0	0	0	0	0	4,525	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	(7,180)	0	0	0	0	0	0	0	0	(7,180)	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	8,455	0	0	0	0	0	0	0	0	8,455	15
16	TOTAL Health Care and Programs	0	0	1,275	0	0	0	0	0	0	0	0	1,275	16
	C. General Administration													
17	Administrative	0	77,424	0	0	0	0	0	0	0	0	0	77,424	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,783)	162,548	1,871	0	0	0	0	0	0	0	0	159,636	19
20	Fees, Subscriptions & Promotions	(71,568)	0	4,220	0	0	0	0	0	0	0	0	(67,348)	20
21	Clerical & General Office Expenses	(72,120)	0	3,849	0	0	0	0	0	0	0	0	(68,271)	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	493	0	0	0	0	0	0	0	0	493	24
25	Other Admin. Staff Transportation	(65)	0	1,103	0	0	0	0	0	0	0	0	1,038	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,682	0	0	0	0	0	0	0	0	3,682	26
27	Other (specify):*	(168,000)	0	25,296	0	0	0	0	0	0	0	0	(142,704)	27
28	TOTAL General Administration	(316,536)	239,972	40,514	0	0	0	0	0	0	0	0	(36,050)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(317,004)	239,972	46,782	0	0	0	0	0	0	0	0	(30,250)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,097)	0	3,936	0	0	0	0	0	0	0	0	(9,161)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(681)	0	1,461	0	0	0	0	0	0	0	0	780	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,194	0	0	0	0	0	0	0	0	14,194	34
35	Rent-Equipment & Vehicles	0	0	8,009	0	0	0	0	0	0	0	0	8,009	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,778)	0	27,600	0	0	0	0	0	0	0	0	13,822	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)**	(330,782)	239,972	74,382	0	0	0	0	0	0	0	0	(16,428)	45

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
KEN RIPSTEIN	95	SEE PAGE 6 SUPP				
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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE-JA	$	JK MANAGEMENT CO	100.00%	$ 37,255	$ 37,255	1
2	V	17	MANAGEMENT FEE-KR		" "		40,169	40,169	2
3	V	19	BOOKKEEPING		" "		162,422	162,422	3
4	V	19	DATA PROCESSING		" "		126	126	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			$			$ 239,972	$ * 239,972	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: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DAMEN HEALTHCARE GROUP, LLC	100.00%	$ 1,731	$ 1,731	15
16	V	3	HOUSEKEEPING		" "		1,628	1,628	16
17	V	6	MAINTENANCE		" "		1,634	1,634	17
18	V	10	NURSING	43,680	" "		36,500	(7,180)	18
19	V	15	NURSING PAYROLL TAXES		" "		8,455	8,455	19
20	V	19	PROFESSIONAL FEES		" "		1,871	1,871	20
21	V	20	DUES, FEES, SUBSCRIPTIONS		" "		4,220	4,220	21
22	V	21	OFFICE EXPENSE	116,500	" "		120,349	3,849	22
23	V	24	SEMINARS & EDUCATION		" "		493	493	23
24	V	25	AUTO EXPENSE		" "		1,103	1,103	24
25	V	26	INSURANCE		" "		3,682	3,682	25
26	V	27	EMPLOYEE BEN, GEN ADMON		" "		25,296	25,296	26
27	V	30	DEPRECIATION		" "		3,936	3,936	27
28	V	32	INTEREST EXPENSE		" "		1,461	1,461	28
29	V	34	RENT		" "		14,194	14,194	29
30	V	35	EQUIPMENT RENTAL		" "		909	909	30
31	V	35	AUTO LEASE		" "		7,100	7,100	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 160,180			$ 234,562	$ * 74,382	39

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			CITADEL CARE CENTER-KANKAKEE	KANKAKEE	DAMEN HEALTHCA	MORTON GROVE	MGMT,BKKP	1
2			CITADEL CARE CENTER-WILMETTE	WILMETTE				2
3			CITADEL CARE CENTER-ELGIN	ELGIN				3
4			WATERFORD CARE CENTER					4
5			CITADEL ESTATES-HAZEL CREST	HAZEL CREST				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: 01/01/2016 Ending: 12/31/2016

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	KEN RIPSTEIN	MEMBER	ADMINISTRATIV	95.00	122,831	9.86		SALARY	$ 40,169	17-7	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	$ 40,169		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: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: DAMEN HEALTHCARE GROUP LLC
Street Address: 5611 DEMPSTER
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (224) 470-2044
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	5	UTILITIES	PATIENT DAYS	236,674	8	$ 9,291	$	44,086	$ 1,731	1
2	3	HOUSEKEEPING	PATIENT DAYS	236,674	8	8,740		44,086	1,628	2
3	6	MAINTENANCE	PATIENT DAYS	236,674	8	8,770		44,086	1,634	3
4	10	NURSING	PATIENT DAYS	236,674	8	195,949	195,949	44,086	36,500	4
5	15	NURSING PAYROLL TAXES	PATIENT DAYS	236,674	8	45,391		44,086	8,455	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	236,674	8	10,042		44,086	1,871	6
7	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	236,674	8	22,657		44,086	4,220	7
8	21	OFFICE EXPENSE	PATIENT DAYS	236,674	8	646,091	586,242	44,086	120,349	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	236,674	8	2,647		44,086	493	9
10	25	AUTO EXPENSE	PATIENT DAYS	236,674	8	5,921		44,086	1,103	10
11	26	INSURANCE	PATIENT DAYS	236,674	8	19,769		44,086	3,682	11
12	27	EMPLOYEE BEN, GEN ADMON	PATIENT DAYS	236,674	8	135,801		44,086	25,296	12
13	30	DEPRECIATION	PATIENT DAYS	236,674	8	21,131		44,086	3,936	13
14	32	INTEREST EXPENSE	PATIENT DAYS	236,674	8	7,844		44,086	1,461	14
15	34	RENT	PATIENT DAYS	236,674	8	76,200		44,086	14,194	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	236,674	8	4,878		44,086	909	16
17	35	AUTO LEASE	PATIENT DAYS	236,674	8	38,115		44,086	7,100	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,237	$ 782,191		$ 234,562	25

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	PRIVATE BANK		X	WORKING CAPITAL							4,629	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 4,629	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 4,629	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	74,400	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.)	$	85,650	2
3. Under or (over) accrual (line 2 minus line 1).	$	11,250	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	90,576	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** $ 200 **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.	$	101,826	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012	56,753	9
2013	58,078	10
2014	72,863	11
2015	85,650	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 2015 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-11-354-001	NURSING HOME	$ 85,650.00	$ 85,650.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 85,650.00	$ 85,650.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	RELATED PARTY				52,480	2,139	20	2,624	485	5,248	7
8											8
	Improvement Type**										
9	100 AMP 3 PHASE SWITCH			2013	6,040	155	39	155		620	9
10	STOREROOM LEVERS, DOOR RESTRICTOR, STAIRWELL LOCK			2013	12,806	328	39	328		1,152	10
11	WIRING FOR PHONE LINES			2013	14,040	360	39	360		1,320	11
12	CHILLER MOTORS, COMPRESSOR, PUMP & MOTOR			2013	30,549	860	39	860		2,842	12
13	COURTYARD PATIO & LANDSCAPING			2013	54,611	3,674	15	3,674		12,809	13
14	REPAVE PARKING LOTS			2013	22,861	1,291	15	1,291		4,868	14
15	CARPET TILES			2013	3,905	100	39	100		325	15
16	BOILER & BACKFLOW PREVENTER			2013	49,086	1,259	39	1,259		3,987	16
17	DRYWALL REPAIR & PAINT			2013	2,020	52	39	52		182	17
18	SHOWER ROOM WORK			2013	5,850	150	39	150		563	18
19	KITCHEN REPAIRS			2013	2,500	64	39	64		235	19
20	DOORS & FRAMES			2013	23,000	590	39	590		2,163	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: 01/01/2016 Ending: 12/31/2016

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	3,590	38
39	EXTERIOR CONCRETE WORK	2013	10,228		39	262	262	917	39
40	EXTERIORSTEEL RAILINGS & HANDRAILS	2013	12,472		39	320	320	1,120	40
41	HVAC SYSTEM	2013	133,093		39	3,412	3,412	11,942	41
42	FIRE SPRINKLER	2013	4,480		39	115	115	402	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	602	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	10,055	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	497	63
64									64
65	EXTERIOR SIDING,PILLARS,TRIM,SHUTTERS	2013	40,590		39	1,041	1,041	3,643	65
66	RECEPTION CABINETS,COLUMNS,GRANITE COUNTER	2013	18,260		39	468	468	1,638	66
67	PLUMBING DRAIN WATER SUPPLY LINES	2013	16,400		39	420	420	1,470	67
68	ELECTRIC FIREPLACE	2013	8,209		39	210	210	735	68
69	ELECTRICAL CONDUIT,WIRE OUTLETS,SWITCHES,FIXTU	2013	38,000		39	974	974	3,409	69
70	TOTAL (lines 4 thru 69)		$ 725,743	$ 11,022		$ 22,942	$ 11,920	$ 76,334	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: 01/01/2016 Ending: 12/31/2016

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		$ 725,743	$ 11,022		$ 22,942	$ 11,920	$ 76,334	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	2,940	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	448	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	3,007	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	149	39	149		421	26
27									27
28	2ND FLOOR HALLWAY-REMOVE ASBESTOS TILE- REPAIR								28
29	CONCRETE FLOOR, INSTALL TILE	2014	47,438	1,216	39	1,216		3,040	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)		$ 850,214	$ 12,387		$ 26,134	$ 13,747	$ 86,190	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: 01/01/2016 Ending: 12/31/2016

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		$ 850,214	$ 12,387		$ 26,134	$ 13,747	$ 86,190	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	39	480		1,440	6
7					39				7
8	FLOORING FOR 1ST & 2ND FLOOR HALLWAYS	2014	18,588	476	39	476		1,328	8
9	COMMERCIAL FIRE ALARM SYSTEM UPGRADE	2014	11,077	284	39	284		781	9
10	2ND FLOOR STAIRWELL LOCKING SYSTEM	2014	3,400	87	39	87		247	10
11	2ND FLOOR AIR CONDITIONING UNITS RESIDENT ROOMS	2014	87,386	2,240	39	2,240		6,126	11
12	1ST FLOOR FLOORING	2014	19,688	505	39	505		1,592	12
13	CEMENT WALKWAY WORK IN GARDEN	2014	5,466	199	27.5	199		415	13
14	1ST FLOOR SHOWER WALLS, FLOORING, DOORS	2014	12,046	438	27.5	438		1,021	14
15	KITCHEN CLOSET, FRONT OFFICE NEW DRYWALL PAINT	2014	1,875	68	27.5	68		153	15
16	CEILING & DRYWALL REPAIR, KITCHEN, BREAKROOM, 1ST FLOOR HALL CLOSET, CONFERENCE ROOM								16
17		2014	11,045	402	27.5	402		820	17
18	CARPETING ALZHEIMER'S UNIT	2015	9,401	342	27.5	342		518	18
19	CHILLER BARREL AND EXPANSION VALVE ASSEMBLY	2015	23,665	860	27.5	860		1,262	19
20	ROOMS 220 & 262 REMOVE & REINSTALL DRYWALL & PA	2015	3,716	135	27.5	135		210	20
21	2ND FLOOR SHOWER ROOM 1,2,& 3 REMOVE & INSTALL DRYWALL & CERMANIC TILE & PLUMBING								21
22		2015	16,695	607	27.5	607		883	22
23	ROOMS 158, 164 & 218 & ACCOUNTING OFFICE REMOVE & REINSTALL DRYWALL & PAINT								23
24		2015	6,960	253	27.5	253		379	24
25	2ND FLOOR NORTH-REMOVE CARPET & TILE REPAIR CONCRETE INSTALL TILE, BASEBOARD, REPAIR WALLS								25
26		2015	26,000	945	27.5	945		1,397	26
27	KITCHEN CEILING, FLOORING REPAIR, INSULATION, TI	2015	8,568	312	27.5	312		463	27
28	TILE & SUPPLIES FOR 2ND FLOOR SHOWER	2015	3,476	126	27.5	126		201	28
29	ROOMS 172, 278, 217 REPAIR, PAINT WALLS & CEILING	2015	14,229	554	27.5	554		805	29
30	TOILET & GRANITE TOPS	2015	885	32	27.5	32		57	30
31	CONVERT SMOKE ROOM TO RESIDENT ROOMS 1ST FLOO	2015	9,789	356	27.5	356		532	31
32	1ST FLOOR DINING ROOM REMOVE WALLPAPER PATCH	2015	4,236	154	27.5	154		229	32
33	1ST FLOOR CONFERENCE REPAIR PATCH PAINT CEILING	2015	5,885	214	27.5	214		314	33
34	TOTAL (lines 1 thru 33)		$ 1,173,025	$ 22,456		$ 36,203	$ 13,747	$ 107,363	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: 01/01/2016 Ending: 12/31/2016

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		$ 1,173,025	$ 22,456		$ 36,203	$ 13,747	$ 107,363	1
2	RESIDENT ROOMS 158,148,152,103 REPAIR WATER DAMAG	2015	4,411	160	27.5	160		235	2
3	DIETARY OFFICE/SHOWER ROOM REPAIR PAINT WALLS	2015	1,512	55	27.5	55		80	3
4	IST FLOOR HALLWAYS, DINING ROOM INSTALL INSULTA	2015	7,835	285	27.5	285		436	4
5	REPAIR WATER DAMAGE LOBBY CEILING	2015	2,430	88	27.5	88		138	5
6	1ST FLOOR RESIDENT RM CEILING REPAIR,PAINTING	2016	41,532	692	27.5	692		692	6
7	2ND FLOOR RESIDENT RM CEILING REAPIR/PAINTING	2016	33,082	551	27.5	551		551	7
8	WOOD DOORS & TRIM 2ND FL NURSE STORAGE CLOSET	2016	2,567	43	27.5	43		43	8
9	& CLEAN UTILITY CLOSET								9
10	FLOORING RM 242,244,222,231,233 1ST FLOOR DINING RM	2016	19,193	320	27.5	320		320	10
11	& DIETARY CORRIDOR				27.5				11
12	ELECTRICAL WORK BASEMENT PANEL, MAIN DISCONNE	2016	11,547	192	27.5	192		192	12
13	PLUMBING, ELECTRICAL,MECHANICAL DESIGN DIALYSI	2016	3,520	59	27.5	59		59	13
14	BOILER SYSTEM #2	2016	7,270	126	27.5	126		126	14
15	NORTH ELEVATOR DOOR OPERATOR UPGRADE	2016	26,806	447	27.5	447		447	15
16	HANDRAILS	2016	1,702	31	27.5	31		31	16
17	GREASE TRAP DIETARY 3 TUB SINK	2016	4,021	70	27.5	70		70	17
18	REPLACED 3 HEAT & COOL UNITS IN DINING ROOM	2016	18,870	307	27.5	307		307	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)		$ 1,359,323	$ 25,882		$ 39,629	$ 13,747	$ 111,090	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: 01/01/2016 Ending: 12/31/2016

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	$ 82,237	$ 6,589	$ 8,223	$ 1,634	10	$ 28,799	71
72	Current Year Purchases	56,425	33,855	5,642	(28,213)	10	5,642	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	15,324	1,797	1,532	(265)	10	2,959	74
75	TOTALS	$ 153,986	$ 42,241	$ 15,397	$ (26,844)		$ 37,400	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)	$ 1,513,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,026	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,097)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 148,490	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: 01/01/2016 Ending: 12/31/2016

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:		141	01/01/2013	$ 300,000	25		3
4	Additions							4
5								5
6								6
7	TOTAL		141		$ 300,000 **			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: [X] 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.	01/01/2017	$ 300,000
13.	01/01/2018	$ 300,000
14.	01/01/2019	$ 300,000

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 23,985 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
18					18
19					19
20					20
21	TOTAL		$	$	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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	$		$ 170,923	$		$ 170,923	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			49,475			49,475	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			443,920			443,920	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				235,502		235,502	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MED SUPPLIES	39-2					2,734		2,734	12
13	Other (specify): LAB,XRAY	39-3				65,376			65,376	13
14	TOTAL			$		$ 729,694	$ 238,236		$ 967,930	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: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 371,430	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 432,833)	3,905,797		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,853		6
7	Other Prepaid Expenses	29,206		7
8	Accounts Receivable (owners or related parties)	89,307		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,529,593	$	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	790,594		15
16	Equipment, at Historical Cost	138,244		16
17	Accumulated Depreciation (book methods)	(162,890)		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): CONSTRUCTION	16,904		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 782,852	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,312,445	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,842,142	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,632		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,852		31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,576		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	1,059,605		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,111,807	$	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)**	$ 3,111,807	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,200,638	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,312,445	$	48

***(See instructions.)**

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,378,807	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,378,807	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	821,831	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) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 821,831	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)**	$ 2,200,638	24 *

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 9,321,279	1
2	Discounts and Allowances for all Levels	(4,955)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,316,324	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	140,261	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 140,261	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***	681	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 681	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)**	$ 9,457,266	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,366,401	31
32	Health Care	3,156,019	32
33	General Administration	2,342,641	33
	B. Capital Expense		
34	Ownership	494,627	34
	C. Ancillary Expense		
35	Special Cost Centers	967,930	35
36	Provider Participation Fee	362,714	36
	D. Other Expenses (specify):		
37	PRIOR ADJUSTMENTS	(54,897)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,635,435	40
41	**Income before Income Taxes (line 30 minus line 40)****	821,831	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 821,831	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,112,871	44
45	Private Pay - Net Inpatient Revenue	721,559	45
46	Medicare - Net Inpatient Revenue	2,570,624	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	916,225	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,321,279	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: 01/01/2016 Ending: 12/31/2016

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	1,912	2,080	$ 77,858	$ 37.43	1
2	Assistant Director of Nursing	1,968	2,080	69,687	33.50	2
3	Registered Nurses	13,175	13,821	381,729	27.62	3
4	Licensed Practical Nurses	26,337	28,791	670,054	23.27	4
5	CNAs & Orderlies	94,062	100,557	1,236,598	12.30	5
6	CNA Trainees					6
7	Licensed Therapist	2,989	3,261	114,632	35.15	7
8	Rehab/Therapy Aides	1,112	1,152	17,851	15.50	8
9	Activity Director	1,964	2,180	40,514	18.58	9
10	Activity Assistants	13,669	14,609	130,980	8.97	10
11	Social Service Workers	2,008	2,080	53,228	25.59	11
12	Dietician					12
13	Food Service Supervisor	248	368	5,736	15.59	13
14	Head Cook	1,529	1,797	15,756	8.77	14
15	Cook Helpers/Assistants	1,743	2,199	16,118	7.33	15
16	Dishwashers					16
17	Maintenance Workers	4,300	4,579	51,898	11.33	17
18	Housekeepers	18,164	21,778	207,375	9.52	18
19	Laundry	9,174	9,789	93,403	9.54	19
20	Administrator	1,928	2,080	106,922	51.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,007	12,910	232,367	18.00	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	888	940	19,271	20.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,177	227,051	$ 3,541,977 *	$ 15.60	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	$ 1,446	1-3	35
36	Medical Director	O	38,500	9-3	36
37	Medical Records Consultant	N	1,789	10-3	37
38	Nurse Consultant	T	2,330	10-3	38
39	Pharmacist Consultant	H	8,798	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)		$ 52,863		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: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAMANTHA BANEY	ADMINISTRATOR		$ 106,922
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 106,922

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 378,263
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 378,263

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		$ 288,936
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 288,936

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 122,323
Unemployment Compensation Insurance	59,990
FICA Taxes	274,136
Employee Health Insurance	130,864
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	21,307
EMPLOYEE PHYSICAL EXAMS	360
PENSION/PROFIT SHARING PLANS	4,323
TOTAL (agree to Schedule V, line 22, col.8)	$ 613,303

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	$ 3,980
Advertising: Employee Recruitment	0
Health Care Worker Background Check	725
(Indicate # of checks performed)	
Patient Background Checks	5,385
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	71,568
LICENSES/DUES/SUBSCRIPTIONS	37,721
MGMT CO ALLOC	4,220
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(59,010)
Yellow page advertising	(12,558)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,031

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	493
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 493

* Attach copy of IMRF notifications

**See instructions.

AMBERWOOD CARE CENTRE
SCHEDULE-LEGAL
12/31/2016

Sum of Debits Description	Effective Date	Ref #	Total
Ashman & Stein Attorneys At Law - AT&J Seminerio v. Amberwood Care Centre			
	25-Aug	071816-082516	1,230.50
MUCH SHELIST - tel conf re: unpaid lunch time for CNAs.			
	1-Oct	455348A	35.67
MUCH SHELIST - United RX - contract review			
	30-Nov	458265	187.50
Stone, McGuire,& Siegel			
	31-Jan	10593	1,000.00
	29-Feb	10704	1,000.00
	31-Mar	10843	1,000.00
	30-Apr	043016	1,000.00
	31-May	11073	1,096.60
	30-Jun	11242	1,000.00
	31-Jul	11287	1,000.00
	31-Aug	11399	1,000.00
	30-Sep	11499	1,000.00
	1-Oct	100116	1,000.00
	31-Oct	103116	1,000.00
	1-Nov	110116	1,000.00
	31-Dec	11779	1,000.00
Simandl Law Group - Wage & Hour Audit			
	31-Mar	28491	2,948.50
	30-Apr	28583	2,904.00
		28584	7,287.50
	31-May	28687	1,247.00
	31-Jul	29020	335.00
Simandl Law Group - Analyze Required Labor Posters			
	30-Jun	28853	172.00
HIPP LAW OFFICE - TAPP			
	29-Jan	012916	1,402.50
	30-Apr	043016	7.00
	31-May	053116	3.50
	30-Jun	063016	7.00
	31-Aug	083116	3.50
	30-Sep	093016	3.50
	31-Oct	103116	3.50
	30-Nov	113016	3.50
	31-Dec	12312016	3.50
Daniel Maher Law Offices - Pharmacy Medication Cut-off Issue			
	11-Oct	10912	100.00
Daniel Maher Law Offices - Wage Garnishment Review			
	11-Oct	10915	300.00
Daniel Maher Law Offices - ALJ hearing			
	11-Oct	10828	60.00
		10916	160.00
Sandberg, Phoenix & Von Gontard, P.C. - A/R Collections			
	30-Nov	392441A	157.59
		392447	2,920.47
		392448A	474.17
Franks, Gerkin & McKenna, P.C. - Monthly Charge			
	6-Feb	17636-000M 8	250.00
	29-Feb	9	125.00
	30-Jun	12	175.00
Daniel Maher Law Offices - Patient Dishcarge - IVD			
	10-Mar	10821	400.00
	29-Mar	10882	240.00
	31-Mar	10879	80.00
	9-Jun	10991	560.00
		10992	60.00
	6-Jul	11024	120.00
		11025	420.00
		11026	180.00
	31-Jul	11067	180.00
	6-Sep	11114	200.00
		11115	40.00
Attorney Sharon Rudy - Flat Fee Charges			
	7-Apr	040716	2,000.00
	28-Sep	03615	2,000.00
MUCH SHELIST - General Counsel			
	1-Feb	443353A	276.42
	31-Mar	446277	169.41
Grand Total			**42,529.83**

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 $20,234**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(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. $ **25,446** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES 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. $ **362,714**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) 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