		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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	PROPRIETARY	GOVERNMENTAL
[ ] 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 ____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 06/30/2021 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)	MELINDA ACTON
	(Title)	ADMINISTRATOR
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
	(Print Name and Title)	KATHLEEN MCNAMARA VICE-PRESIDENT
	(Firm Name & Address)	KBKB, LTD 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
	(Telephone)	(847) 675-3585 Fax # (847) 675-3585

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA Telephone Number: (847) 675-3585
Email Address:

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: 1/1/2020 Ending: 06/30/2021

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds ______

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			6,111	6,111	8
9	SNF/PED					9
10	ICF	28,702	5,627	1,338	35,667	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,702	5,627	7,449	41,778	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.96%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 6,111

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	268,142	36,303	9,212	313,657		313,657		313,657			1
2	Food Purchase		263,222		263,222		263,222	(25)	263,197			2
3	Housekeeping	175,991	51,238		227,229		227,229	1,517	228,746			3
4	Laundry	81,878	14,114		95,992		95,992		95,992			4
5	Heat and Other Utilities			160,141	160,141		160,141	1,255	161,396			5
6	Maintenance	56,854	28,942	94,848	180,644		180,644	(7,434)	173,210			6
7	Other (specify):*			30,664	30,664		30,664	2,523	33,187			7
8	TOTAL General Services	582,865	393,819	294,865	1,271,549		1,271,549	(2,164)	1,269,385			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,675,570	236,536	177,775	4,089,881		4,089,881	(33,475)	4,056,406			10
10a	Therapy	176,240		16,975	193,215		193,215		193,215			10a
11	Activities	114,728	7,579		122,307		122,307		122,307			11
12	Social Services	58,430			58,430		58,430		58,430			12
13	CNA Training											13
14	Program Transportation			7,476	7,476		7,476		7,476			14
15	Other (specify):*							21,231	21,231			15
16	TOTAL Health Care and Programs	4,024,968	244,115	238,226	4,507,309		4,507,309	(12,244)	4,495,065			16
	C. General Administration											
17	Administrative	104,036		422,362	526,398		526,398	(119,694)	406,704			17
18	Directors Fees											18
19	Professional Services			322,242	322,242		322,242	(143,719)	178,523			19
20	Dues, Fees, Subscriptions & Promotions			78,359	78,359		78,359	(23,319)	55,040			20
21	Clerical & General Office Expenses	230,807	31,943	154,913	417,663		417,663	(47,656)	370,007			21
22	Employee Benefits & Payroll Taxes			670,707	670,707		670,707		670,707			22
23	Inservice Training & Education			3,283	3,283		3,283		3,283			23
24	Travel and Seminar			9,972	9,972		9,972	(5,297)	4,675			24
25	Other Admin. Staff Transportation							2,714	2,714			25
26	Insurance-Prop.Liab.Malpractice			418,947	418,947		418,947	3,408	422,355			26
27	Other (specify):*			263,976	263,976		263,976	(224,547)	39,429			27
28	TOTAL General Administration	334,843	31,943	2,344,761	2,711,547		2,711,547	(558,110)	2,153,437			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,942,676	669,877	2,877,852	8,490,405		8,490,405	(572,518)	7,917,887			29

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

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

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,212	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		0	
				9,212
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		0	
				0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,344	
	ELECTRICITY		56,386	
	WATER		60,672	
	CABLE TV - LOBBY		19,739	
				160,141
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,295	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		41,509	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		9,059	
	OUTSIDE LABOR		12,000	
	EXTERMINATING SERVICE		6,600	
	FIRE SERVICE		1,309	
	ALLOCATED MAINTENANCE		21,076	
				94,848
7	**OTHER**			
	SCAVENGER		30,664	
	SECURITY SERVICE		0	
				30,664
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		36,000	36,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2		
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,216	
	PHARMACY CONSULTANT	XVIII B 39-2	8,921	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	5,500	
	PROGRAM CONSULTANT		25,483	
	ALLOCATED NURSING		135,655	
				177,775
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	16,975	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				16,975
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

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		7,476	
				7,476
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	422,362	422,362
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	138,660	
	ADMINISTRATIVE CONSULTANTS	XIX C	18,300	
	PROFESSIONAL FEES	XIX C	21,282	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		144,000	
				322,242
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	19,580	
	EMPLOYEE WANT ADS	XIX F	3,230	
	CONTRIBUTIONS	VI 20 XIX F	600	
	DUES & SUBSCRIPTIONS	XIX F	38,524	
	LICENSES & PERMITS	XIX F	7,843	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	2,655	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,000	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	2,007	
	PATIENT BACKGROUND CHECKS	XIX F	1,920	
				78,359
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		18,356	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	962	
	HOME OFFICE EXPENSE		114,602	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,993	
	MESSENGER SERVICE		0	
				154,913

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	369,811	
	UNEMPLOYMENT COMPENSATION	XIX D	43,067	
	WORKERS COMPENSATION INSURANCE	XIX D	75,450	
	HOSPITALIZATION INSURANCE	XIX D	133,931	
	EMPLOYEE BENEFITS - OTHER	XIX D	21,492	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,308	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	23,648	
	401K CONTRIBUTION MATCH			
				670,707
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		3,283	
				3,283
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	9,972	
				9,972
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		0	
				0
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		418,947	
				418,947
27	**OTHER**			
	BAD DEBTS	VI 24	263,976	
				263,976

GRAND TOTAL COLUMN 3 OTHER **2,877,852**

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			98,244	98,244		98,244	(12,102)	86,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							6,866	6,866			32
33	Real Estate Taxes			85,052	85,052		85,052	7,041	92,093			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	15,166	315,166			34
35	Rent-Equipment & Vehicles			57,462	57,462		57,462	7,930	65,392			35
36	Other (specify):*											36
37	**TOTAL Ownership**			540,758	540,758		540,758	24,901	565,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		271,676	474,241	745,917		745,917		745,917			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			293,907	293,907		293,907		293,907			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		271,676	768,148	1,039,824		1,039,824		1,039,824			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,942,676	941,553	4,186,758	10,070,987		10,070,987	(547,617)	9,523,370			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: 1/1/2020 Ending: 06/30/2021

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	(16,309)	30		9
10	Interest and Other Investment Income	(783)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	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	(962)	21		18
19	Entertainment		20		19
20	Contributions	(2,600)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(263,976)	27		24
25	Fund Raising, Advertising and Promotional	(19,580)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,655)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(275,969)	22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (582,859)		$	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)	35,242		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 35,242		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (547,617)		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 | Page 5A

AMBERWOOD CARE CENTRE

ID# 0052191

Report Period Beginning: 1/1/2020

Ending: 06/30/2021

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (90,602)	21	1
2	MARKETING TRAVEL	(5,342)	24	2
3	MARKETING AUTO LEASE	(7,663)	35	3
4	MANAGEMENT FEES	(172,362)	17	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
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31				31
32				32
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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**	(275,969)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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	(25)	0	0	0	0	0	0	0	0	0	0	(25)	2
3	Housekeeping	0	0	1,517	0	0	0	0	0	0	0	0	1,517	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,255	0	0	0	0	0	0	0	0	1,255	5
6	Maintenance	0	0	(7,645)	211	0	0	0	0	0	0	0	(7,434)	6
7	Other (specify):*	0	0	2,523	0	0	0	0	0	0	0	0	2,523	7
8	**TOTAL General Services**	(25)	0	(2,350)	211	0	0	0	0	0	0	0	(2,164)	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	(33,475)	0	0	0	0	0	0	0	0	(33,475)	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	21,231	0	0	0	0	0	0	0	0	21,231	15
16	**TOTAL Health Care and Programs**	0	0	(12,244)	0	0	0	0	0	0	0	0	(12,244)	16
	C. General Administration													
17	Administrative	(172,362)	0	52,668	0	0	0	0	0	0	0	0	(119,694)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(143,719)	0	0	0	0	0	0	0	0	(143,719)	19
20	Fees, Subscriptions & Promotions	(24,835)	0	1,516	0	0	0	0	0	0	0	0	(23,319)	20
21	Clerical & General Office Expenses	(91,564)	0	43,908	0	0	0	0	0	0	0	0	(47,656)	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	(5,342)	0	45	0	0	0	0	0	0	0	0	(5,297)	24
25	Other Admin. Staff Transportation	0	0	2,714	0	0	0	0	0	0	0	0	2,714	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,408	0	0	0	0	0	0	0	0	3,408	26
27	Other (specify):*	(263,976)	0	39,429	0	0	0	0	0	0	0	0	(224,547)	27
28	**TOTAL General Administration**	(558,079)	0	(31)	0	0	0	0	0	0	0	0	(558,110)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(558,104)	0	(14,625)	211	0	0	0	0	0	0	0	(572,518)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(16,309)	0	2,501	1,706	0	0	0	0	0	0	0	(12,102)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(783)	0	2,514	5,135	0	0	0	0	0	0	0	6,866	32
33	Real Estate Taxes	0	0	0	7,041	0	0	0	0	0	0	0	7,041	33
34	Rent-Facility & Grounds	0	0	22,908	(7,742)	0	0	0	0	0	0	0	15,166	34
35	Rent-Equipment & Vehicles	(7,663)	0	15,593	0	0	0	0	0	0	0	0	7,930	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,755)	0	43,516	6,140	0	0	0	0	0	0	0	24,901	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)**	(582,859)	0	28,891	6,351	0	0	0	0	0	0	0	(547,617)	45

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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
		SEE PAGE 6 SUPP				

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	26	INSURANCE	$ 366,000	BILTMORE INCORPORATED CELL		$ 366,000	$	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			$ 366,000			$ 366,000	$ *	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: 1/1/2020 Ending: 06/30/2021

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	DAMEN HEALTHCARE GROUP LLC		$ 1,517	$ 1,517	15
16	V	5	UTILITIES		DAMEN HEALTHCARE GROUP LLC		1,255	1,255	16
17	V	6	MAINTENANCE SALARY		DAMEN HEALTHCARE GROUP LLC		11,870	11,870	17
18	V	6	MAINTENANCE	21,076	DAMEN HEALTHCARE GROUP LLC		1,561	(19,515)	18
19	V	7	MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP LLC		2,523	2,523	19
20	V	10	NURSING	135,655	DAMEN HEALTHCARE GROUP LLC		102,180	(33,475)	20
21	V	15	NURSING BENEFITS		DAMEN HEALTHCARE GROUP LLC		21,231	21,231	21
22	V	17	ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP LLC		26,334	26,334	22
23	V	19	PROFESSIONAL FEES	144,000	DAMEN HEALTHCARE GROUP LLC		281	(143,719)	23
24	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP LLC		1,516	1,516	24
25	V	21	OFFICE SALARY		DAMEN HEALTHCARE GROUP LLC		147,767	147,767	25
26	V	21	OFFICE EXPENSE	114,602	DAMEN HEALTHCARE GROUP LLC		10,743	(103,859)	26
27	V	24	SEMINARS & EDUCATION		DAMEN HEALTHCARE GROUP LLC		45	45	27
28	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP LLC		2,714	2,714	28
29	V	26	INSURANCE		DAMEN HEALTHCARE GROUP LLC		3,408	3,408	29
30	V	27	EMPLOYEE BEN G&A		DAMEN HEALTHCARE GROUP LLC		39,429	39,429	30
31	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP LLC		2,501	2,501	31
32	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP LLC		2,514	2,514	32
33	V	34	RENT		DAMEN HEALTHCARE GROUP LLC		22,908	22,908	33
34	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP LLC		838	838	34
35	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP LLC		14,755	14,755	35
36	V	17	ADMIN FEES - K RIPSTEIN		DAMEN HEALTHCARE GROUP LLC		26,334	26,334	36
37	V								37
38	V								38
39	Total			$ 415,333			$ 444,224	$ * 28,891	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: 1/1/2020 Ending: 06/30/2021

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINTENANCE	$	3755 W CHASE, LLC		$ 211	$ 211	15
16	V	30	DEPRECIATION		3755 W CHASE, LLC		1,706	1,706	16
17	V	32	INTEREST EXPENSE		3755 W CHASE, LLC		5,135	5,135	17
18	V	33	REAL ESTATE TAXES		3755 W CHASE, LLC		5,986	5,986	18
19	V	33	REAL ESTATE TAX PROTEST FEES		3755 W CHASE, LLC		1,055	1,055	19
20	V	34	RENT	7,742	3755 W CHASE, LLC			(7,742)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,742			$ 14,093	$ * 6,351	39

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

STATE OF ILLINOIS

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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	KENNETH RIPSTEIN	98.00	CITADEL OF ELGIN	ELGIN	DAMEN HEALTHCA	SKOKIE	HOME OFFICE	1
2	YAEL BELLOWS RIPSTEIN	2.00	CITADEL ESTATES	HAZEL CREST	GROUP			2
3			CITADEL OF KANKAKEE	KANKAKEE	JK MANAGEMENT (	MORTON GROVE		3
4			CITADEL OF NORTHBROOK	NORTHBROOK				4
5			PA PETERSON AT THE CITADEL	ROCKFORD				5
6			CITADEL OF STERLING	STERLING				6
7			WATERFORD CARE CENTER	CHICAGO				7
8			CITADEL OF WILMETTE	WILMETTE				8
9					3755 CHASE, LLC	SKOKIE	BUILDING COMP	9
10			WARREN PARK HEALTH AND LIVING CEN	CHICAGO	BILTMORE INC. CE	BURLINGTON, VT	INSURANCE	10
11			SKOKIE MEADOWS LLC	SKOKIE	INTEGRA HEALTH(	ELMHURSE	DME	11
12			CITADEL OF SKOKIE	SKOKIE	LIFELINE AMBULA	SKOKIE	AMBULANCE	12
13			CITADEL OF GLENVIEW	GLENVIEW				13
14			CITADEL OF COURBONNAIS	BOURBONNAIS				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: 1/1/2020 Ending: 06/30/2021

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	KENNETH RIPSTEIN	MEMBER	ADMINISRATIVE	98.00	SEE ATTACHED	4.21	10.53	SALARY	$ 26,334	17-7	1
2	KENNETH RIPSTEIN	MEMBER	ADMINISRATIVE		SCHEDULE			MGMT FEE	250,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 276,334		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: 1/1/2020 Ending: 6/30/2021

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: 3755 W. CHASE AVE.
City / State / Zip Code: SKOKIE, IL 60076
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	3	HOUSEKEEPING	PATIENT DAYS	396,623	14	$ 14,400	$	41,778	$ 1,517	1
2	5	UTILITIES	PATIENT DAYS	396,623	14	11,913		41,778	1,255	2
3	6	MAINTENANCE SALARY	PATIENT DAYS	396,623	14	112,690	112,690	41,778	11,870	3
4	6	MAINTENANCE	PATIENT DAYS	396,623	14	14,821		41,778	1,561	4
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	396,623	14	23,951		41,778	2,523	5
6	10	NURSING	PATIENT DAYS	396,623	14	970,057	948,342	41,778	102,180	6
7	15	NURSING BENEFITS	PATIENT DAYS	396,623	14	201,561		41,778	21,231	7
8	17	ADMINISTRATIVE	PATIENT DAYS	396,623	14	250,000	250,000	41,778	26,334	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	396,623	14	2,669		41,778	281	9
10	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	396,623	14	14,390		41,778	1,516	10
11	21	OFFICE SALARIES	PATIENT DAYS	396,623	14	1,402,841	1,402,841	41,778	147,767	11
12	21	OFFICE EXPENSE	PATIENT DAYS	396,623	14	101,995		41,778	10,744	12
13	24	SEMINARS & EDUCATION	PATIENT DAYS	396,623	14	431		41,778	45	13
14	25	AUTO EXPENSE	PATIENT DAYS	396,623	14	25,762		41,778	2,714	14
15	26	INSURANCE	PATIENT DAYS	396,623	14	32,350		41,778	3,408	15
16	27	EMPLOYEE BENEFIT - G&A	PATIENT DAYS	396,623	14	374,325		41,778	39,429	16
17	30	DEPRECIATION	PATIENT DAYS	396,623	14	23,745		41,778	2,501	17
18	32	INTEREST EXPENSE	PATIENT DAYS	396,623	14	23,867		41,778	2,514	18
19	34	RENT	PATIENT DAYS	396,623	14	143,975		41,778	15,166	19
20	34	RENT	PATIENT DAYS	396,623	14	73,500		41,778	7,742	20
21	35	EQUIPMENT RENTAL	PATIENT DAYS	396,623	14	7,954		41,778	838	21
22	35	AUTO LEASE	PATIENT DAYS	396,623	14	140,073		41,778	14,754	22
23	17	ADMIN FEES - J AARON	PATIENT DAYS	354,845	14	250,000		41,778	0	23
24	17	ADMIN FEES - K RIPSTEIN	PATIENT DAYS	396,623	14	250,000		41,778	26,334	24
25	TOTALS					$ 4,467,270	$ 2,713,873		$ 444,224	25

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 6/30/2021

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: 3755 W CHASE, LLC
Street Address: 3755 W CHASE, LLC
City / State / Zip Code: SKOKIE, IL 60076
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	6	MAINTENANCE	PAITENT DAYS	396,623	14	$ 2,000	$	41,778	$ 211	1
2	30	DEPRECIATION	PAITENT DAYS	396,623	14	16,199		41,778	1,706	2
3	32	INTEREST EXPENSE	PAITENT DAYS	396,623	14	48,746		41,778	5,135	3
4	33	REAL ESTATE TAXES	PAITENT DAYS	396,623	14	56,831		41,778	5,986	4
5	33	REAL ESTATE TAX PROTEST I	PAITENT DAYS	396,623	14	10,020		41,778	1,055	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					$ 133,796	$		$ 14,093	25

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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												6
7	RELATED PARTY										7,649	7
8												8
9	**TOTAL Facility Related**						$	$			$ 7,649	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$ 7,649	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: 1/1/2020 Ending: 06/30/2021

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.	$	88,706	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.)	$	84,760	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,946)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,998	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.	$	85,052	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	85,650	8
	2016	84,585	9
	2017	84,662	10
	2018	85,086	11
	2019	84,760	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBERWOOD CARE CENTRE COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0052191

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-11-354-001	NURSING HOME	$ 84,759.58	$ 84,759.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 84,759.58	$ 84,759.58

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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).

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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					2,613		2,286	(327)		7
8											8
	Improvement Type**										
9	100 AMP 3 PHASE SWITCH			2013	6,040		39	155	155	1,240	9
10	STOREROOM LEVERS, DOOR RESTRICTOR, STAIRWELL LOCK			2013	12,806		39	328	328	2,464	10
11	WIRING FOR PHONE LINES			2013	14,040		39	360	360	2,760	11
12	CHILLER MOTORS, COMPRESSOR, PUMP & MOTOR			2013	30,549		39	860	860	6,282	12
13	COURTYARD PATIO & LANDSCAPING			2013	54,611		15	3,674	3,674	27,505	13
14	REPAVE PARKING LOTS			2013	22,861		15	1,291	1,291	10,032	14
15	CARPET TILES			2013	3,905		39	100	100	725	15
16	BOILER & BACKFLOW PREVENTER			2013	49,086		39	1,259	1,259	9,023	16
17	DRYWALL REPAIR & PAINT			2013	2,020		39	52	52	390	17
18	SHOWER ROOM WORK			2013	5,850		39	150	150	1,163	18
19	KITCHEN REPAIRS			2013	2,500		39	64	64	491	19
20	DOORS & FRAMES			2013	23,000		39	590	590	4,523	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: 1/1/2020 Ending: 06/30/2021

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	7,694	38
39	EXTERIOR CONCRETE WORK	2013	10,228		39	262	262	1,965	39
40	EXTERIORSTEEL RAILINGS & HANDRAILS	2013	12,472		39	320	320	2,400	40
41	HVAC SYSTEM	2013	133,093		39	3,412	3,412	25,590	41
42	FIRE SPRINKLER	2013	4,480		39	115	115	862	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	1,290	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	21,547	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	1,065	63
64									64
65	EXTERIOR SIDING,PILLARS,TRIM,SHUTTERS	2013	40,590		39	1,041	1,041	7,807	65
66	RECEPTION CABINETS,COLUMNS,GRANITE COUNTER	2013	18,260		39	468	468	3,510	66
67	PLUMBING DRAIN WATER SUPPLY LINES	2013	16,400		39	420	420	3,150	67
68	ELECTRIC FIREPLACE	2013	8,209		39	210	210	1,575	68
69	ELECTRICAL CONDUIT,WIRE OUTLETS,SWITCHES,FIXTU	2013			39	974	974	7,305	69
70	TOTAL (lines 4 thru 69)		$ 635,263	$ 2,613		$ 22,604	$ 19,991	$ 152,358	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: 1/1/2020 Ending: 06/30/2021

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		$ 635,263	$ 2,613		$ 22,604	$ 19,991	$ 152,358	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	6,300	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	960	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	6,443	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		39	149	149	1,017	26
27									27
28	2ND FLOOR HALLWAY-REMOVE ASBESTOS TILE- REPAIR								28
29	CONCRETE FLOOR, INSTALL TILE	2014	47,438		39	1,216	1,216	7,904	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)		$ 759,734	$ 2,613		$ 25,796	$ 23,183	$ 174,982	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: 1/1/2020 Ending: 06/30/2021

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		$ 759,734	$ 2,613		$ 25,796	$ 23,183	$ 174,982	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		39	480	480	2,880	6
7									7
8	FLOORING FOR 1ST & 2ND FLOOR HALLWAYS	2014	18,588		39	476	476	2,756	8
9	COMMERCIAL FIRE ALARM SYSTEM UPGRADE	2014	11,077		39	284	284	1,633	9
10	2ND FLOOR STAIRWELL LOCKING SYSTEM	2014	3,400		39	87	87	508	10
11	2ND FLOOR AIR CONDITIONING UNITS RESIDENT ROOMS	2014	87,386		39	2,240	2,240	12,846	11
12	1ST FLOOR FLOORING	2014	19,688		39	505	505	3,107	12
13	CEMENT WALKWAY WORK IN GARDEN	2014	5,466		27.5	199	199	1,012	13
14	1ST FLOOR SHOWER WALLS, FLOORING, DOORS	2014	12,046		27.5	438	438	2,335	14
15	KITCHEN CLOSET, FRONT OFFICE NEW DRYWALL PAINT	2014	1,875		27.5	68	68	357	15
16	CEILING & DRYWALL REPAIR, KITCHEN, BREAKROOM, 1ST FLOOR HALL CLOSET, CONFERENCE ROOM								16
17		2014	11,045		27.5	402	402	2,026	17
18	CARPETING ALZHEIMER'S UNIT	2015	9,401		27.5	342	342	1,544	18
19	CHILLER BARREL AND EXPANSION VALVE ASSEMBLY	2015	23,665		27.5	860	860	3,842	19
20	ROOMS 220 & 262 REMOVE & REINSTALL DRYWALL & PA	2015	3,716		27.5	135	135	615	20
21	2ND FLOOR SHOWER ROOM 1,2,& 3 REMOVE & INSTALL DRYWALL & CERMANIC TILE & PLUMBING								21
22		2015	16,695		27.5	607	607	2,704	22
23	ROOMS 158, 164 & 218 & ACCOUNTING OFFICE REMOVE & REINSTALL DRYWALL & PAINT								23
24		2015	6,960		27.5	253	253	1,138	24
25	2ND FLOOR NORTH-REMOVE CARPET & TILE REPAIR CONCRETE INSTALL TILE, BASEBOARD, REPAIR WALLS								25
26		2015	26,000		27.5	945	945	4,232	26
27	KITCHEN CEILING, FLOORING REPAIR, INSULATION, TI	2015	8,568		27.5	312	312	1,399	27
28	TILE & SUPPLIES FOR 2ND FLOOR SHOWER	2015	3,476		27.5	126	126	579	28
29	ROOMS 172, 278, 217 REPAIR, PAINT WALLS & CEILING	2015	14,229		27.5	554	554	2,467	29
30	TOILET & GRANITE TOPS	2015	885		27.5	32	32	153	30
31	CONVERT SMOKE ROOM TO RESIDENT ROOMS 1ST FLO	2015	9,789		27.5	356	356	1,600	31
32	1ST FLOOR DINING ROOM REMOVE WALLPAPER PATCH	2015	4,236		27.5	154	154	691	32
33	1ST FLOOR CONFERENCE REPAIR PATCH PAINT CEILIN	2015	5,885		27.5	214	214	956	33
34	TOTAL (lines 1 thru 33)		$ 1,082,545	$ 2,613		$ 35,865	$ 33,252	$ 226,362	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: 1/1/2020 Ending: 06/30/2021

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		$ 1,082,545	$ 2,613		$ 35,865	$ 33,252	$ 226,362	1
2	RESIDENT ROOMS 158,148,152,103 REPAIR WATER DAMAG	2015	4,411		27.5	160	160	875	2
3	DIETARY OFFICE/SHOWER ROOM REPAIR PAINT WALLS	2015	1,512		27.5	55	55	300	3
4	IST FLOOR HALLWAYS, DINING ROOM INSTALL INSULTA	2015	7,835		27.5	285	285	1,576	4
5	REPAIR WATER DAMAGE LOBBY CEILING	2015	2,430		27.5	88	88	490	5
6	1ST FLOOR RESIDENT RM CEILING REPAIR,PAINTING	2016	41,532		27.5	692	692	3,460	6
7	2ND FLOOR RESIDENT RM CEILING REAPIR/PAINTING	2016	33,082		27.5	551	551	2,755	7
8	WOOD DOORS & TRIM 2ND FL NURSE STORAGE CLOSET	2016	2,567		27.5	43	43	215	8
9	& CLEAN UTILITY CLOSET								9
10	FLOORING RM 242,244,222,231,233 1ST FLOOR DINING RM	2016	19,193		27.5	320	320	1,600	10
11	& DIETARY CORRIDOR								11
12	ELECTRICAL WORK BASEMENT PANEL, MAIN DISCONNE	2016	11,547		27.5	192	192	960	12
13	PLUMBING, ELECTRICAL,MECHANICAL DESIGN DIALYSI	2016	3,520		27.5	59	59	295	13
14	BOILER SYSTEM #2	2016	7,270		27.5	126	126	630	14
15	NORTH ELEVATOR DOOR OPERATOR UPGRADE	2016	26,806		27.5	447	447	2,235	15
16	HANDRAILS	2016	1,702		27.5	31	31	155	16
17	GREASE TRAP DIETARY 3 TUB SINK	2016	4,021		27.5	70	70	350	17
18	REPLACED 3 HEAT & COOL UNITS IN DINING ROOM	2016	18,870		27.5	307	307	1,535	18
19	1st FLOOR DINING ROOM, FLOORING, DRYWALL REPAIR, WALLPAPER, PAINTING								19
20		2017	37,418		27.5	1,361	1,361	5,444	20
21	ROOMS 218,220,227,229,REMOVE OLD & INSTALL NEW FLOORING, PAINT BATHROOMS, INSTALL WALLPAPER, CERAMIC TILE & FIXTU								21
22		2017	76,000		27.5	2,764	2,764	11,056	22
23	LAUNDRY CHUTES	2017	5,584		27.5	203	203	812	23
24	HOT WATER BOILER WITH PUMP	2017	30,218		27.5	1,099	1,099	4,396	24
25	ROOF REPAIR	2017	14,000		27.5	509	509	2,036	25
26	GENERATOR	2017	33,807		27.5	1,229	1,229	4,916	26
27	REPLACE 1ST STAGE COMPRESSOR ON CHILLER	2017	28,170		27.5	1,024	1,024	4,096	27
28	NEW BEGINNINGS UNIT-REMOVE WALLPALER, REPAIR DRYWALL, PAINT, DOORS & JAMS SANDED AND PAINTED								28
29		2017	12,315		27.5	448	448	1,792	29
30	1ST FLOOR BREAK ROOM, REMOVE & REPAIR CEILING, WALLS, DRYWALL, PAINT, INSTALL FLOORING, COVE BASE								30
31		2018	3,617		27.5	132	132	396	31
32	DINING ROOMS-REMOVE WALLPAPER, REPAIR WALL, PA	2018	3,157		27.5	115	115	345	32
33	MAIN DINING ROOM FLOORING	2018	13,420		27.5	488	488	1,464	33
34	TOTAL (lines 1 thru 33)		$ 1,526,549	$ 2,613		$ 48,663	$ 46,050	$ 280,546	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: 1/1/2020 Ending: 06/30/2021

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 12D, Carried Forward		$ 1,526,549	$ 2,613		$ 48,663	$ 46,050	$ 280,546	1
2	BASEMENT CEILING REPAIR	2018	1,659		27.5	60	60	180	2
3	1ST FL DINING ROOM- INSTALL CHERRY MOLDING, CORNER GUARDS, PAINT DOORS								3
4		2018	5,247		27.5	191	191	4,017	4
5	PLUMBING,ELECTRICAL, MECHANICAL DESIGN	2018	880		27.5	32	32	96	5
6	REPLACE MIXING VALVE CARTRIDGE	2018	1,300		27.5	47	47	141	6
7	KITCHEN - REPIPE PREP SINK AND PLUMBING REPAIRS	2018	7,305		27.5	266	266	798	7
8	2ND FL RESIDENT ROOMS 230,232,234,236 FLOORING, PAINT, ELECTRICAL, PLUMBING								8
9		2018	12,000		27.5	436	436	1,308	9
10	REPLACE GREASE TRAP	2018	4,730		27.5	172	172	516	10
11	2ND FL ACTIVITY STORAGE ROOM DOOR, NE STAIRWELL EXIT DOOR, REPAIR DRYWALL								11
12		2018	3,881		27.5	141	141	423	12
13	DISCHARGE PUMP & PIPING	2019	5,648		27.5	205	205	410	13
14	GALVANIZED STEEL DOOR & FRAME	2019	2,097		27.5	76	76	152	14
15	CORRIDOR BASE, WALLCOVERING, PAINT, VINYL, MILL	2019	82,842		27.5	3,012	3,012	6,024	15
16	RESIDENT ROOM 2FL REMOVE, INTALL, REAPIR WALLS	2019	2,146		27.5	78	78	156	16
17	REMOVE & INSTALL NEW KITCHEN FLOOR	2019	1,065		27.5	39	39	78	17
18	RM 112,142,111 REMOVE & INSTALL TILE	2019	3,860		27.5	140	140	280	18
19	RM 152,162,164 REPAIR CEILING & WALLS	2019	4,520		27.5	164	164	328	19
20	1ST FL FRONT OFFICE WALLPAPER	2019	850		27.5	31	31	62	20
21	GARBAGE DISPOSAL	2019	4,608		27.5	168	168	336	21
22	1ST FL ELEVATOR NR 1&2 WALLAPER	2019	760		27.5	28	28	56	22
23	EMPLOYEE BREAK RM REPAIR CEILING & WALLS	2019	1,280		27.5	47	47	94	23
24	RM 104,146,150,152 REMOVE AND INSTALL FLOOR TILE	2019	2,442		27.5	89	89	178	24
25	ROOM 217 -INSTALL NEW CERAMIC TILE	2020	3,435		27.5	57	57	57	25
26									26
27									27
28									28
29									29
30				98,244			(98,244)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,679,104	$ 100,857		$ 54,142	$ (46,715)	$ 296,236	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: 1/1/2020 Ending: 06/30/2021

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	$ 232,167	$	$ 25,552	$ 25,552		$ 123,299	71
72	Current Year Purchases	48,543		4,854	4,854		4,854	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		1,594	1,594				74
75	TOTALS	$ 280,710	$ 1,594	$ 32,000	$ 30,406		$ 128,153	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)	$ 1,959,814	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 102,451	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,142	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (16,309)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 424,389	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: 1/1/2020 Ending: 06/30/2021

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	02/01/2013	$ 300,000	25		3
4	Additions							4
5								5
6								6
7	TOTAL		141		$ 300,000 **			7

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.	01/01/2021	$ 300,000
13.	01/01/2022	$ 300,000
14.	01/01/2023	$ 300,000

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 19,794 Description: SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SCHEDULE ATTACHED		$	$ 37,668	17
18					18
19					19
20					20
21	TOTAL		$	$ 37,668	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.

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.

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.

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	$		$ 156,358	$		$ 156,358	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			105,845			105,845	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			212,038			212,038	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				196,745		196,745	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): RENTALS						74,931		0 74,931	13
14	TOTAL			$		$ 474,241	$ 271,676		$ 745,917	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: 1/1/2020 Ending: 06/30/2021

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2021 (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	$ 2,395,735	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 378,125)	3,103,830		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	428,450		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)**	$ 5,957,221	$	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	1,200,854		15
16	Equipment, at Historical Cost	273,691		16
17	Accumulated Depreciation (book methods)	(479,847)		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): DEPOSITS	36,459		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,031,157	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,988,378	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 738,896	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,128,830		29
30	Accrued Salaries Payable	205,962		30
31	Accrued Taxes Payable (excluding real estate taxes)	229,793		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,998		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	LOAN PAYABLE	935,109		36
37	ACCRUED RENT PAYABLE	1,577,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,904,588	$	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)**	$ 4,904,588	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,083,790	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,988,378	$	48

*(See instructions.)

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,281,368	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,281,368	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,465,149	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	(662,727)	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)**	$ 802,422	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)**	$ 2,083,790	24 *

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

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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	$ 10,298,091	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,298,091	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	261,882	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 261,882	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***	783	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 783	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	STIMULUS PAYMENT	910,735	28
28a	PRIOR ADJ	64,645	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 975,380	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,536,136	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,271,549	31
32	Health Care	4,507,309	32
33	General Administration	2,711,547	33
	B. Capital Expense		
34	Ownership	540,758	34
	C. Ancillary Expense		
35	Special Cost Centers	745,917	35
36	Provider Participation Fee	293,907	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,070,987	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,465,149	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,465,149	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,293,893	44
45	Private Pay - Net Inpatient Revenue	1,067,826	45
46	Medicare - Net Inpatient Revenue	2,589,686	46
47	Other-(specify) VETERAN	292,931	47
48	Other-(specify) MANAGED CARE	1,053,755	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,298,091	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: 1/1/2020 Ending: 06/30/2021

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,848	2,129	$ 103,656	$ 48.69	1
2	Assistant Director of Nursing	1,871	2,144	82,985	38.71	2
3	Registered Nurses	14,290	15,313	568,766	37.14	3
4	Licensed Practical Nurses	23,724	25,708	904,580	35.19	4
5	CNAs & Orderlies	98,930	106,969	1,953,371	18.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,756	6,411	176,240	27.49	8
9	Activity Director	1,956	2,114	33,033	15.63	9
10	Activity Assistants	6,596	7,050	81,695	11.59	10
11	Social Service Workers	2,023	2,534	58,430	23.06	11
12	Dietician					12
13	Food Service Supervisor	2,192	2,390	49,516	20.72	13
14	Head Cook	6,497	7,085	94,143	13.29	14
15	Cook Helpers/Assistants	11,114	11,913	124,483	10.45	15
16	Dishwashers					16
17	Maintenance Workers	2,024	2,578	56,854	22.05	17
18	Housekeepers	14,408	15,530	175,991	11.33	18
19	Laundry	7,123	7,452	81,878	10.99	19
20	Administrator	1,976	2,112	104,036	49.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,416	5,886	230,807	39.21	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					31
32	Other Health Care(specify)					32
33	Other(specify) ADMISSION	5,501	5,981	62,212	10.40	33
34	TOTAL (lines 1 - 33)	213,245	231,299	$ 4,942,676 *	$ 21.37	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,212	1-3	35
36	Medical Director	O	36,000	9-3	36
37	Medical Records Consultant	N	2,216	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,921	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		16,975	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)		$ 73,324		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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: 1/1/2020 Ending: 06/30/2021

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAMANTHA BANEY	ADMINISTRATOR	0	$ 104,036
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 104,036

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 422,362
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 422,362

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		322,242
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 322,242

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,450
Unemployment Compensation Insurance	43,067
FICA Taxes	369,811
Employee Health Insurance	133,931
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	21,492
EMPLOYEE PHYSICAL EXAMS	3,308
PENSION/PROFIT SHARING PLANS	23,648
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 670,707

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	$
Advertising: Employee Recruitment	3,230
Health Care Worker Background Check	2,007
(Indicate # of checks performed)	
Patient Background Checks	1,920
TRUST/FRANCHISE/CONTRIB/ETC	2,600
MARKETING/ADV/PROMO	22,235
LICENSES/DUES/SUBSCRIPTIONS	46,367
MGMT CO ALLOC	1,516
TRUST/FRANCHISE/CONTRIB/ETC	(2,600)
Less: Public Relations Expense	(0)
Non-allowable advertising	(19,580)
Yellow page advertising	(2,655)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,040

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	9,972
MGMT CO ALLOC	2,714
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,686

* Attach copy of IMRF notifications

**See instructions.

AMBERWOOD CARE CENTRE
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
3/31/2020	BEN LAZARE CONSULTING	CONSULTING FOR MARCH 2020	1,000
4/30/2020	BEN LAZARE CONSULTING	CONSULTING FOR APRIL 2020	1,000
4/30/2020	BRIAN K. LARKING ATTORNEY AT LAW	CHRISTINE CONKLING	504
8/31/2019	MUCH SHELIST	BIOMETRIC SUIT	864
11/30/2019	MUCH SHELIST	BREACH OF CONTRACT	401
1/31/2020	MUCH SHELIST	GENERAL COUNSELING	2,173
2/29/2020	MUCH SHELIST	ONGOING GENERAL COUNSEL	902
3/31/2020	MUCH SHELIST	GENERAL COUNSELING	800
3/31/2020	MUCH SHELIST	GENERAL COUNSELING-COVID	247
5/31/2020	MUCH SHELIST	GENERAL COUNSELING	328
6/30/2020	MUCH SHELIST	GENERAL COUNSELING	164
7/31/2020	MUCH SHELIST	070820, 072720: RE: MERVY HEALTH, NH20-C0048	246
8/31/2020	MUCH SHELIST	ONGOING GENERAL COUNSEL	246
9/30/2020	MUCH SHELIST	ONGOING GENERAL COUNSEL	246
10/1/2020	MUCH SHELIST	ONGOING GENERAL COUNSEL	96
10/31/2020	MUCH SHELIST	GENERAL COUNSELING	410
11/30/2020	MUCH SHELIST	GENERAL COUNSELING	82
2/29/2020	SANDBERG PHOENIX	PREPARE DOCS RE COLL TM STRATEGY	24
4/9/2020	SANDBERG PHOENIX	STRATEGIZE CASES	94
6/30/2020	SANDBERG PHOENIX	GENERAL COUNSELING	71
3/11/2020	SAUL EWING ARSTEIN & KEHR, LLP	REVIEW DOCUMENTS: 1.3HRS	700
7/10/2020	SAUL EWING ARSTEIN & KEHR, LLP	REVIEW OF LOAN MODIFICATION DOCUMENTS: 1.7HR	697
1/2/2020	SB2 INC	MONTHLY PROJECT FEE	750
1/2/2020	SB2 INC	MONTHLY PROJECT FEE	250
2/3/2020	SB2 INC	MONTHLY PROJECT FEE	250
2/3/2020	SB2 INC	MONTHLY PROJECT FEE	750
3/2/2020	SB2 INC	MONTHLY PROJECT FEE	250
3/2/2020	SB2 INC	MONTHLY PROJECT FEE	750
1/1/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
2/1/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
3/31/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
4/30/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
5/31/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
6/30/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
7/31/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
8/31/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
9/30/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
10/31/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
11/30/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
12/31/2020	STONE MCGUIRE & SIEGEL	COMPLIANCE REVIEW	1,000
12/31/2020	TRANSITIONS SETTLEMENT	LEGAL FEES	(25,120)
		TOTAL	1,174

Facility Name & ID Number AMBERWOOD CARE CENTRE # 0052191 Report Period Beginning: 1/1/2020 Ending: 06/30/2021

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. ______

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? ______

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,060** 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 ______ 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. $ **293,907**
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.