



Facility Name & ID Number Amboy Terrace

# 0036715 Report Period Beginning: 07/01/07 Ending: 06/30/08

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,625</u>			<u>5,625</u>
14	TOTALS	<u>5,625</u>			<u>5,625</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.06%

D. How many bed-hold days during this year were paid by the Department?

35 (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)

\_\_\_\_\_

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 01/02/91

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 01/02/91 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number Amboy Terrace # 0036715 Report Period Beginning: 07/01/07 Ending: 06/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	41,923		1,230	43,153		43,153	43,153			1
2	Food Purchase		41,275		41,275		41,275	41,275			2
3	Housekeeping	23,433	8,543	607	32,583		32,583	32,583			3
4	Laundry	7,811			7,811		7,811	7,811			4
5	Heat and Other Utilities			20,880	20,880		20,880	20,880			5
6	Maintenance	17,553	14,190	1,661	33,404		33,404	33,404			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>90,720</b>	<b>64,008</b>	<b>24,378</b>	<b>179,106</b>		<b>179,106</b>	<b>179,106</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	358,176	28,102	996	387,274		387,274	387,274			10
10a	Therapy			473	473		473	473			10a
11	Activities	11,128	1,448		12,576		12,576	12,576			11
12	Social Services	2,767		209	2,976		2,976	2,976			12
13	CNA Training	5,564			5,564		5,564	5,564			13
14	Program Transportation			8,241	8,241		8,241	8,241			14
15	Other (specify):* Client Advoc/Psych	3,042	586		3,628		3,628	3,628			15
16	<b>TOTAL Health Care and Programs</b>	<b>380,677</b>	<b>30,136</b>	<b>9,919</b>	<b>420,732</b>		<b>420,732</b>	<b>420,732</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	37,263		89,363	126,626		126,626	126,626			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			1,832	1,832		1,832	1,832			20
21	Clerical & General Office Expenses		3,235	2,817	6,052		6,052	6,052			21
22	Employee Benefits & Payroll Taxes			179,516	179,516		179,516	179,516			22
23	Inservice Training & Education			2,043	2,043		2,043	2,043			23
24	Travel and Seminar			3,171	3,171		3,171	3,171			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			5,452	5,452		5,452	5,452			26
27	Other (specify):*			13	13		13	13			27
28	<b>TOTAL General Administration</b>	<b>37,263</b>	<b>3,235</b>	<b>284,207</b>	<b>324,705</b>		<b>324,705</b>	<b>324,705</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>508,660</b>	<b>97,379</b>	<b>318,504</b>	<b>924,543</b>		<b>924,543</b>	<b>924,543</b>			<b>29</b>

\*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.

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			53,109	53,109	53,109	53,109				30
31	Amortization of Pre-Op. & Org.										31
32	Interest			4,546	4,546	4,546	4,546				32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds			3,480	3,480	3,480	3,480				34
35	Rent-Equipment & Vehicles			204	204	204	204				35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			61,339	61,339	61,339	61,339				37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			55,048	55,048	55,048	55,048				42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			55,048	55,048	55,048	55,048				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	508,660	97,379	434,891	1,040,930	1,040,930	1,040,930	1,040,930			45

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

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**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$		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.

		1	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

Amboy Terrace

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Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	<b>Total</b>	0	49





Facility Name & ID Number Amboy Terrace

# 0036715

Report Period Beginning:

07/01/07

Ending:

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**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kreider Services, Inc.	100	Blackhawk Group Home	Dixon			
Kreider Services, Inc.	100	Ashton Terrace Group Home	Ashton			
Kreider Services, Inc.	100	Pine Acres Group Home	Dixon			
Kreider Services, Inc.	100	Boyd, Division, Wasson Group Home	Amboy			
Kreider Services, Inc.	100	Franklin Grove, Ottawa, First St. Group Home	Franklin Grove, Dixon			
Kreider Services, Inc.	100	New Main Group Home	Dixon			
Kreider Services, Inc.	100	Rachuy Group Home	Stockton			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number Amboy Terrace # 0036715 Report Period Beginning: 07/01/07 Ending: 06/30/08

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Kreider Services, Inc.  
 Street Address 500 Anchor Road  
 City / State / Zip Code Dixon, Illinois 61021  
 Phone Number ( 815-288-6691  
 Fax Number ( 815-288-1636

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	Ln 17, Col 3	Central Office Costs	# of clients	34	\$ 1,638,992	\$ 1,025,472		\$ 89,363	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,638,992	\$ 1,025,472		\$ 89,363	25

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Kreider Services Foundation		x	Mortgage Loan	\$2,900.00	12/22/99	\$ 250,000	\$ 48,856	12/22/09	0.0695	\$ 4,547	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$2,900.00		\$ 250,000	\$ 48,856			\$ 4,547	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 250,000	\$ 48,856			\$ 4,547	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.)

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2007 report.		\$ 0	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.)		\$ 0	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 0	3																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 0	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 0	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ 0	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 0	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>0</td><td>8</td></tr> <tr><td>2004</td><td>0</td><td>9</td></tr> <tr><td>2005</td><td>0</td><td>10</td></tr> <tr><td>2006</td><td>0</td><td>11</td></tr> <tr><td>2007</td><td>0</td><td>12</td></tr> </table>	2003	0	8	2004	0	9	2005	0	10	2006	0	11	2007	0	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003	0	8																														
2004	0	9																														
2005	0	10																														
2006	0	11																														
2007	0	12																														
<b>FOR BHF USE ONLY</b>																																
13	FROM R. E. TAX STATEMENT FOR 2007 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Amboy Terrace COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0036715

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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        NO

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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 Amboy Terrace

# 0036715 Report Period Beginning:

07/01/07 Ending:

06/30/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 6,295 B. General Construction Type: Exterior vinyl siding Frame wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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	<u>building</u>	<u>25,200</u>	<u>1992</u>	<u>\$ 13,924</u>	<u>1</u>
2	<u>land improvement</u>			<u>20,000</u>	<u>2</u>
3	<b>TOTALS</b>	<b>25,200</b>		<b>\$ 33,924</b>	<b>3</b>

Facility Name & ID Number Amboy Terrace

# 0036715

Report Period Beginning:

07/01/07

Ending:

06/30/08

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1990	\$ 371,500	\$ 14,860	25	\$ 14,860		\$ 252,620	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Paint			1995	1,880		5			1,880	9
10	Architectural Plan & Engineering			1999	16,398	784	25	784		7,213	10
11	Remodel Bathroom			1999	7,667	767	10	767		6,964	11
12	Wall guard			1999	6,878		5			6,878	12
13	Addition			2000	216,176	8,632	25	8,632		73,370	13
14	Packing Area Expansion			2001	2,349		2			2,349	14
15	Building 25 1/2 x 32' x 10' down payment			2001	1,404	70	20	70		538	15
16	Building Addition			2001	3,120	125	25	125		947	16
17	Kitchen cabinets			2001	4,670	311	15	311		2,335	17
18	Carpet for Living Room			2001	3,798	380	10	380		2,817	18
19	Shelter barn			2001	7,673	307	25	307		2,276	19
20	Apron for Bus Area			2001	500	33	15	33		231	20
21	Bus Barn			2001	2,600	173	15	173		1,199	21
22	Asphalt Back Lot			2002	4,092	511	8	511		2,899	22
23	Driveway			2006	1,850	231	8	231		482	23
24	Humidifiers installed on furnace			2008	1,040	23	15	23		23	24
25	Replacement roof			2008	6,352	106	10	106		106	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 Amboy Terrace

# 0036715

Report Period Beginning:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 659,947	\$ 27,313		\$ 27,313	\$	\$ 365,127	70

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

Facility Name & ID Number Amboy Terrace # 0036715 Report Period Beginning: 07/01/07 Ending: 06/30/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 56,709	\$ 5,731	\$ 5,731	\$		\$ 38,444	71
72	Current Year Purchases	4,097	433	433			433	72
73	Fully Depreciated Assets	8,663	24	24			8,663	73
74								74
75	TOTALS	\$ 69,469	\$ 6,188	\$ 6,188	\$		\$ 47,540	75

D. Vehicle Depreciation (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	Residential Transport	2005 Ford Eldorado	2005	\$ 48,396	\$ 12,099	\$ 12,099	\$	4	\$ 34,281	76
77										77
78										78
79										79
80	TOTALS			\$ 48,396	\$ 12,099	\$ 12,099	\$		\$ 34,281	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)	\$ 811,736	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,600	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,600	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 446,948	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	corporate equipment	\$	\$ 3,385	\$	86
87	corporate vehicle		1,410		87
88	corporate leasehold improvement		2,714		88
89					89
90					90
91	TOTALS	\$	\$ 7,509	\$	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 Amboy Terrace

# 0036715

Report Period Beginning: 07/01/07

Ending: 06/30/08

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ 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	<b>TOTAL</b>		\$	\$	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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>50</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		2,140		2,140
4	Clinical Wages (b)		3,424		3,424
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,564	\$	\$ 5,564
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,564		

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>4</b>

- (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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 Amboy Terrace# 0036715Report Period Beginning: 07/01/07

Ending:

06/30/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$	\$	10
	<b>B. Long-Term Assets</b>			
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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$	\$	25

		1	2		
		Operating	After		
			Consolidation*		
	<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$	26	
27	Officer's Accounts Payable			27	
28	Accounts Payable-Patient Deposits			28	
29	Short-Term Notes Payable			29	
30	Accrued Salaries Payable			30	
31	Accrued Taxes Payable (excluding real estate taxes)			31	
32	Accrued Real Estate Taxes(Sch.IX-B)			32	
33	Accrued Interest Payable			33	
34	Deferred Compensation			34	
35	Federal and State Income Taxes			35	
	<b>Other Current Liabilities(specify):</b>				
36				36	
37				37	
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$	\$	38	
	<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39	
40	Mortgage Payable			40	
41	Bonds Payable			41	
42	Deferred Compensation			42	
	<b>Other Long-Term Liabilities(specify):</b>				
43				43	
44				44	
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45	
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$	\$	46	
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$	(13,083)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$	(13,083)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 61,736	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 61,736	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(74,819)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (74,819)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (13,083)	24 *

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

Facility Name & ID Number Amboy Terrace# 0036715Report Period Beginning: 07/01/07Ending: 06/30/08**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 934,254	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 934,254	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	11,730	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 11,730	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	145	24
25	Interest and Other Investment Income***	11,193	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,338	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc. Income	7,434	28
28a	QMRP Income	1,355	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,789	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 966,111	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	179,106	31
32	Health Care	420,732	32
33	General Administration	324,705	33
<b>B. Capital Expense</b>			
34	Ownership	61,339	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	55,048	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,040,930	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(74,819)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (74,819)	43

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

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

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Amboy Terrace

# 0036715

Report Period Beginning:

07/01/07

Ending:

06/30/08

**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	
2	Assistant Director of Nursing				2	
3	Registered Nurses	186	215	5,517	25.66	3
4	Licensed Practical Nurses	1,808	2,044	35,098	17.17	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	936	1,040	11,128	10.70	10
11	Social Service Workers	169	181	2,767	15.29	11
12	Dietician					12
13	Food Service Supervisor	101	120	1,966	16.38	13
14	Head Cook	63	75	902	12.03	14
15	Cook Helpers/Assistants	3,285	3,650	39,055	10.70	15
16	Dishwashers					16
17	Maintenance Workers	1,093	1,259	17,553	13.94	17
18	Housekeepers	1,971	2,190	23,433	10.70	18
19	Laundry	657	730	7,811	10.70	19
20	Administrator					20
21	Assistant Administrator	1,781	2,223	37,263	16.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,876	2,212	47,770	21.60	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	22,007	23,740	275,355	11.60	30
31	Medical Records					31
32	Other Health Care(specify)	106	124	3,042	24.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	36,039	39,803	\$ 508,660 *	\$ 12.78	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	\$ 1,230	Ln.1, Col.3	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant		Ln.10, Col.3	38
39	Pharmacist Consultant	238	Ln.10, Col.3	39
40	Physical Therapy Consultant	473	Ln.10a, Col.3	40
41	Occupational Therapy Consultant		Ln.10a, Col.3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant		Ln.10a, Col.3	43
44	Activity Consultant		Ln.11, Col.3	44
45	Social Service Consultant	209	Ln.12, Col.3	45
46	Other(specify)		Ln.10, Col.3	46
47	Physician/Psychologist/Dentist	757	Ln.10, Col.3	47
48			Ln.17, Col.3	48
49	TOTAL (lines 35 - 48)	\$ 2,907		49

**C. CONTRACT NURSES**

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





**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? no  
If YES, give association name and amount. \_\_\_\_\_
- (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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ we do not track Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,048  
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? n/a
- (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? n/a 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. \$ n/a Has any meal income been offset against related costs? n/a Indicate the amount. \$ 0
- (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? yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,873  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: CLIFTON GUNDERSON LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. it is not yet finalized
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? n/a
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? \_\_\_\_\_  
Attach invoices and a summary of services for all architect and appraisal fees.