

		FOR BHF USE				

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IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0036715

Facility Name: Amboy Terrace

Address: 200 West Hawley Amboy 61310
 Number City Zip Code

County: Lee

Telephone Number: 815-288-6691 Fax # 815-288-1636

HFS ID Number: _____

Date of Initial License for Current Owners: 1/2/91

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____

In the event there are further questions about this report, please contact:
 Name: Edward S. Roller Telephone Number: 815-288-6691
 Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/13 to 06/30/14 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.

(Signed) _____ (Date) _____

Officer or Administrator of Provider (Type or Print Name) Edward S. Roller

(Title) Director of Finance

(Signed) _____ (Date) _____

Paid Preparer (Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () () Fax # () ()

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 Amboy Terrace

0036715 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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	5,460			5,460
14	TOTALS	5,460			5,460

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.49%

D. How many bed-hold days during this year were paid by the Department? 49 (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 1/2/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/2/91 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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/14 Fiscal Year: 6/30/14

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

Facility Name & ID Number

Amboy Terrace

0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14

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
	A. General Services										
1	Dietary	42,369		1,320	43,689		43,689	43,689			1
2	Food Purchase		50,755		50,755		50,755	50,755			2
3	Housekeeping	23,586	7,328		30,914		30,914	30,914			3
4	Laundry	7,862			7,862		7,862	7,862			4
5	Heat and Other Utilities			18,602	18,602		18,602	18,602			5
6	Maintenance	18,771	15,819	2,188	36,778		36,778	36,778			6
7	Other (specify):*										7
8	TOTAL General Services	92,588	73,902	22,110	188,600		188,600	188,600			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	387,305	21,498	2,266	411,069		411,069	411,069			10
10a	Therapy										10a
11	Activities	11,201	1,739		12,940		12,940	12,940			11
12	Social Services	2,950			2,950		2,950	2,950			12
13	CNA Training	8,408			8,408		8,408	8,408			13
14	Program Transportation			10,007	10,007		10,007	10,007			14
15	Other (specify):*	3,260	1,354		4,614		4,614	4,614			15
16	TOTAL Health Care and Programs	413,124	24,591	12,273	449,988		449,988	449,988			16
	C. General Administration										
17	Administrative	39,885		81,146	121,031		121,031	121,031			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			1,146	1,146		1,146	1,146			20
21	Clerical & General Office Expenses		7,436	2,813	10,249		10,249	10,249			21
22	Employee Benefits & Payroll Taxes			163,778	163,778		163,778	163,778			22
23	Inservice Training & Education			2,661	2,661		2,661	2,661			23
24	Travel and Seminar			2,854	2,854		2,854	2,854			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,012	4,012		4,012	4,012			26
27	Other (specify):*										27
28	TOTAL General Administration	39,885	7,436	258,410	305,731		305,731	305,731			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	545,597	105,929	292,793	944,319		944,319	944,319			29

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

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

Facility Name & ID Number

Amboy Terrace

#0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			39,800	39,800		39,800		39,800			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			3,237	3,237		3,237		3,237			34
35	Rent-Equipment & Vehicles			500	500		500		500			35
36	Other (specify):*											36
37	TOTAL Ownership			43,537	43,537		43,537		43,537			37
	Ancillary Expense											
	E. Special Cost Centers											
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			58,052	58,052		58,052		58,052			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			58,052	58,052		58,052		58,052			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	545,597	105,929	394,382	1,045,908		1,045,908		1,045,908			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 Amboy Terrace

0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (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. (See instructions.)

		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Amboy Terrace

ID# 0036715

Report Period Beginning: 07/01/13

Ending: 06/30/14

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

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				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Amboy Terrace

0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Amboy Terrace

0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

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
Kreider Services, Inc.	100	Pine Acres Group Home	Dixon			
Kreider Services, Inc.	100	Blackhawk Group Home	Dixon			
Kreider Services, Inc.	100	Ashton Terrace Group Home	Ashton			
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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Amboy Terrace

0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Amboy Terrace # 0036715 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

Facility Name & ID Number Amboy Terrace

0036715

Report Period Beginning:

07/01/13

Ending: 06/30/14

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

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

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

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	\$ 1,501,626	\$ 953,851		\$ 81,144	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				\$ 1,501,626	\$ 953,851		\$ 81,144	25

Facility Name & ID Number

Amboy Terrace

0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$						

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

		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 2013 report.		\$			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.)		\$			2														
3. Under or (over) accrual (line 2 minus line 1).		\$			3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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.		\$			7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009 _____	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010 _____	9																	
	2011 _____	10																	
	2012 _____	11																	
	2013 _____	12																	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A)	(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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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

C. **Tax Bills**

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

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Amboy Terrace

0036715 Report Period Beginning:

07/01/13 Ending:

06/30/14

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).

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>1992</u>	<u>\$ 13,924</u>	1
2	<u>Land Improvement</u>		<u>1999</u>	<u>20,000</u>	2
3	TOTALS			\$ 33,924	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$	\$ 341,780
5									
6									
7									
8									
Improvement Type**									
9	Paint		1995	1,880		5			1,880
10	Architectural Plan & Engineering		1999	16,398	784	25	784		11,919
11	Remodel Bathroom		1999	7,667		10			7,603
12	Wall guard		1999	6,878		5			6,878
13	Addition		2000	215,795	8,633	25	8,633		125,162
14	Packing Area Expansion		2001	2,349		2			2,349
15	Building 25 1/2 x 32' x 10' down payment		2001	1,404	70	20	70		959
16	Building Addition		2001	3,120	125	25	125		1,695
17	Kitchen cabinets		2001	4,670	311	15	311		4,203
18	Carpet for Living Room		2001	3,798		10			3,798
19	Shelter barn		2001	7,673	307	25	307		4,118
20	Apron for Bus Area		2001	500	33	15	33		431
21	Bus Barn		2001	2,600	173	15	173		2,239
22	Asphalt Back Lot		2002	4,092		8			4,092
23	Driveway		2006	1,850	212	8	212		1,850
24	Humidifiers installed on furnace		2008	1,040	69	15	69		439
25	Replacement roof		2008	6,352	636	10	636		3,917
26	2 replacement furnaces		2009	3,872	258	15	258		1,549
27	Air conditioner		2009	2,068	138	15	138		827
28	Central Air Conditioning		2011	3,300	660	5	660		2,035
29									
30									
31									
32									
33									
34									
35									
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:

07/01/13

Ending:

06/30/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$ 668,806	\$ 27,269		\$ 27,269	\$	\$ 529,723	70

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

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	\$ 44,868	\$ 3,633	\$ 3,633	\$		\$ 32,577	71
72	Current Year Purchases	16,571	841	841			841	72
73	Fully Depreciated Assets	39,664					39,664	73
74								74
75	TOTALS	\$ 101,103	\$ 4,474	\$ 4,474	\$		\$ 73,082	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	Residential Transport	2005 Ford Eldorado 11 pass	2005	\$ 48,396	\$	\$	\$	4	\$ 48,396	76
77										77
78										78
79										79
80	TOTALS			\$ 48,396	\$	\$	\$		\$ 48,396	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)	\$ 852,229	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,743	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,743	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)	\$ 651,201	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	\$	\$ 3,317	\$	86
87	Corporate Vehicle		1,172		87
88	Corporate Leasehold		3,568		88
89					89
90					90
91	TOTALS	\$	\$ 8,057	\$	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: 07/01/13

Ending: 06/30/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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	TOTAL				\$			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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?</p> <p><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>
---	--	---

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)		3,234		3,234
4	Clinical Wages (b)		5,174		5,174
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,408	\$	\$ 8,408
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,408		

- (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.

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	TOTAL			\$		\$		\$								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: 07/01/13

Ending:

06/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/14

(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	\$	\$	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	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	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			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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	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)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (383,802)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (383,802)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (296,134)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (296,134)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(87,668)	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)	\$ (87,668)	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)	\$ (383,802)	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 929,779	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 929,779	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,366	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)	\$ 15,366	23
D. Non-Operating Revenue			
24	Contributions	755	24
25	Interest and Other Investment Income***	2,302	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,057	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		2,779	28
28a		7,259	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,038	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 958,240	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	188,600	31
32	Health Care	449,988	32
33	General Administration	305,731	33
B. Capital Expense			
34	Ownership	43,537	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	58,052	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,045,908	40
41	Income before Income Taxes (line 30 minus line 40)**	(87,668)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (87,668)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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:

07/01/13

Ending:

06/30/14

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	207	5,900	25.65	3
4	Licensed Practical Nurses	1,692	38,026	20.23	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	11,201	10.77	10
11	Social Service Workers	160	2,950	16.57	11
12	Dietician				12
13	Food Service Supervisor	124	2,131	15.44	13
14	Head Cook	67	927	12.53	14
15	Cook Helpers/Assistants	3,285	39,311	10.77	15
16	Dishwashers				16
17	Maintenance Workers	989	18,771	17.06	17
18	Housekeepers	1,971	23,586	10.77	18
19	Laundry	657	7,862	10.77	19
20	Administrator				20
21	Assistant Administrator	2,160	39,885	16.62	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)	2,187	51,339	21.13	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	25,107	300,448	10.77	30
31	Medical Records				31
32	Other Health Care(specify)	113	3,260	25.87	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	39,655	44,063	\$ 545,597 *	\$ 12.38 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	\$	Ln.1, Col. 3	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	300	Ln. 10, Col. 3	39
40	Physical Therapy Consultant	564	Ln. 10a, Col. 3	40
41	Occupational Therapy Consultant			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		Ln. 12, Col. 3	45
46	Other(specify) <u>Behavior Specialist</u>	263	Ln. 10, Col. 3	46
47	<u>Physician</u>	818	Ln. 10, Col. 3	47
48	<u>Psychiatrist</u>	321	Ln. 10, Col. 3	48
49	TOTAL (lines 35 - 48)	\$ 2,266		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
P. Howard/R. Heiderscheid	Manager		\$ 11,169	Workers' Compensation Insurance	\$ 17,964	IDPH License Fee	\$	
K. Shuey/P. Lane	Supervisor		28,716	Unemployment Compensation Insurance	7,017	Advertising: Employee Recruitment	483	
				FICA Taxes	38,345	Health Care Worker Background Check		
				Employee Health Insurance	93,159	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	186	
				403B Pension Plan	3,131	Dues	19	
				Tuition Reimbursement		Misc. Fees	104	
				Christmas Gift/Party	111	DOT Drug Screen/Physicals	329	
				Physical Exam	1,269	Dept of Fin Reg	25	
				Accrued Vacation Pay	2,782	Less: Public Relations Expense	()	
				Trf to Capital - Maintenance		Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 39,885	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
Allocation of Mgt and General			\$ 81,146					
Consultant Expense - Legal								
Consultant Expense - Other								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 81,146	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
			\$				Out-of-State Travel	\$
							In-State Travel	2,854
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL		\$	TOTAL	\$ 2,854

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Amboy Terrace# 0036715

Report Period Beginning:

07/01/13

Ending:

06/30/14**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? _____
- (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 10 COL 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 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. \$ 58,052
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? 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. \$ N/A 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. \$ 0
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 LARSON ALLEN LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.