		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0020925

Facility Name: NORTH ADAMS HOME

Address: 2259 E. 1100TH STREET (Number) MENDON (City) 62351 (Zip Code)

County: ADAMS

Telephone Number: 217-936-2137 **Fax #** 217-936-2659

HFS ID Number:

Date of Initial License for Current Owners: 10/16/1977

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501©3

In the event there are further questions about this report, please contact:
Name: ROBYN JOHNSON **Telephone Number:** 217-936-2137
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 11/01/09 to 10/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) ROBYN JOHNSON
(Title) ADMINISTRATOR

Paid Preparer
(Signed) (Date)
(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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	92	33,860	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	92	33,860	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,539	7,782	3,839	28,160	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,539	7,782	3,839	28,160	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.17%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/16/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 92 and days of care provided 3,839

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 10/31/10 Fiscal Year: 10/31/10

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

STATE OF ILLINOIS

Facility Name & ID Number NORTH ADAMS HOME # 0020925 **Report Period Beginning:** 11/01/09 **Ending:** 10/31/10

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	202,471	6,276	13,893	222,640		222,640		222,640			1
2	Food Purchase		163,643		163,643		163,643		163,643			2
3	Housekeeping	60,746	11,344	109	72,199		72,199		72,199			3
4	Laundry	81,728	4,943	1,642	88,313		88,313		88,313			4
5	Heat and Other Utilities			101,200	101,200		101,200	(12,796)	88,404			5
6	Maintenance	53,077	6,323	28,914	88,314		88,314		88,314			6
7	Other (specify):*											7
8	**TOTAL General Services**	398,022	192,529	145,758	736,309		736,309	(12,796)	723,513			8
	B. Health Care and Programs											
9	Medical Director	55,614			55,614		55,614		55,614			9
10	Nursing and Medical Records	1,200,423	95,206	42,590	1,338,219		1,338,219	(500)	1,337,719			10
10a	Therapy	10,771	303	234,177	245,251		245,251		245,251			10a
11	Activities	89,722	6,704		96,426		96,426		96,426			11
12	Social Services	46,749		4,589	51,338		51,338		51,338			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,403,279	102,213	281,356	1,786,848		1,786,848	(500)	1,786,348			16
	C. General Administration											
17	Administrative	65,204			65,204		65,204		65,204			17
18	Directors Fees											18
19	Professional Services			33,034	33,034		33,034		33,034			19
20	Dues, Fees, Subscriptions & Promotions			37,802	37,802		37,802		37,802			20
21	Clerical & General Office Expenses	144,969	28,300	204,292	377,561		377,561	(118,144)	259,417			21
22	Employee Benefits & Payroll Taxes			259,857	259,857		259,857		259,857			22
23	Inservice Training & Education			1,521	1,521		1,521		1,521			23
24	Travel and Seminar			8,657	8,657		8,657		8,657			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,213	21,213		21,213		21,213			26
27	Other (specify):*											27
28	**TOTAL General Administration**	210,173	28,300	566,376	804,849		804,849	(118,144)	686,705			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,011,474	323,042	993,490	3,328,006		3,328,006	(131,440)	3,196,566			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 NORTH ADAMS HOME #0020925 **Report Period Beginning:** 11/01/09 **Ending:** 10/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			152,241	152,241		152,241	(19,821)	132,420			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,683	134,683		134,683	(2,718)	131,965			32
33	Real Estate Taxes			12,381	12,381		12,381	(3,821)	8,560			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							500	500			35
36	Other (specify):*											36
37	**TOTAL Ownership**			299,305	299,305		299,305	(25,860)	273,445			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	15,493	516		16,009		16,009		16,009			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	15,493	516		16,009		16,009		16,009			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,026,967	323,558	1,292,795	3,643,320		3,643,320	(157,300)	3,486,020			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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	2,718			18
19	Entertainment				19
20	Contributions	25			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	113,982			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	40,575			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 157,300		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 157,300		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

NORTH ADAMS HOME

ID# 0020925

Report Period Beginning: 11/01/09

Ending: 10/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COTTAGES - UTILITY EXPENSE	$ 12,796	5-21	1
2	COTTAGES - REPAIRS & MAINTENANCE	2,289	5-21	2
3	COTTAGES - INSURANCE	1,848	5-21	3
4	COTTAGES - REAL ESTATE TAXES	3,821	5-21	4
5	COTTAGES- DEPRECIATION	19,821	30-5	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**	40,575		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTH ADAMS HOME **#** 0020925 **Report Period Beginning:** 11/01/09 **Ending:** 10/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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 NORTH ADAMS HOME **#** 0020925 **Report Period Beginning:** 11/01/09 **Ending:** 10/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

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

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST BANKERS TRUST		X	IST MORTGAGE	$6,697.00		$ 2,000,000	$ 898,282	03/04/2025	3.6300	$ 43,089	1
2	FIRST BANKERS TRUST		X	2ND MORTGAGE	$4,234.00		530,000	413,141	03/24/2013	7.2500	31,162	2
3	NRTH ADAMS STATE BANK		X	CASH FLOW	$2,702.00		250,000	33,920		7.0000	3,069	3
4	INTERNAL REVENUE SERVICE		X	TAX	$2,800.00			329,497		5.0000	19,487	4
5												5
	Working Capital											
6	NORTH ADAMS STATE BANK		X	LINE OF CREDIT			100,000	100,000		7.5000	7,345	6
7	NORTH ADAMS STATE BANK		X	EQUIPMENT	$761.00		50,000	42,969		3.0000	3,921	7
8												8
9	TOTAL Facility Related				$17,194.00		$ 2,930,000	$ 1,817,809			$ 108,073	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,930,000	$ 1,817,809			$ 108,073	15

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

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

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 9,420	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.)		$ 11,891	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,471	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 9,909	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.		$ 12,380	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006		9
2007		10
2008	11,296	11
2009	11,891	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTH ADAMS HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT ROBYN JOHNSON

TELEPHONE 217-936-2137 FAX #: 217-936-2659

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-0-0708-004-00	COMMERCIAL	$ 11,891.00	$ 8,222.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 11,891.00	$ 8,222.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? x 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,950 B. General Construction Type: Exterior brick Frame fire resistant Number of Stories 1

C. Does the Operating Entity? [x] (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? [x] (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)

MEDICAL CLINIC - 2,567 SQ. FT
COTTAGES - 2,756 SQ. FT.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	PATIENT CARE	435,600	1975	$ 72,758	1
2					2
3	TOTALS	435,600		$ 72,758	3

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1977	1977	$ 740,276	$ 13,537	40	$ 13,537	$	$ 669,628	4
5	1		1977	1986	438,224	14,607	30	14,607		350,568	5
6	10		1977	1990	31,318	1,044	30	1,044		20,792	6
7			2001	1997	1,374,932	34,373	40	34,373		446,849	7
8											8
	Improvement Type**										
9	ROOM FURNITURE			2005	11,322	755	15	755		4,605	9
10	PTAC HEATING A/C UNIT			2005	965	64	15	64		320	10
11	FRONT OFFICE LOCKS			2004	1,221	122	10	122		1,037	11
12	RESIDENT ROOM GLASS (5)			2004	735	74	10	74		444	12
13	PTAC HEATING A/C UNITS (6)			2004	8,512	567	15	567		3,812	13
14	COMPACTOR ELECTRICAL WIRING			2004	750	75	10	75		450	14
15	WATER SOFTENER ELEMENTS & RESIN			2004	2,438	244	10	244		1,464	15
16	PARKING LOT IMPROVEMENTS			2004	3,869	(1)	5	(1)		3,869	16
17	PLUMBING REPLACEMENT DRAIN PIPE			2004	1,000	40	25	40		240	17
18	AIR CURTAIN			2004	578	39	15	39		234	18
19	PTAC HEATING A/C UNITS (2)			2003	2,062	206	10	206		1,448	19
20	GENERATOR			2002	18,497	925	20	925		7,400	20
21	WALL PANEL			2004	1,829	183	10	183		1,098	21
22	ACTIVITY ROOM FLOORING			2002	4,308	431	10	431		3,448	22
23	CONCRETE WORK			2002	937	47	20	47		376	23
24	PARKING LOT LIGHT			2002	788	53	15	53		424	24
25	ROOM REMODEL			2002	9,522	635	15	635		5,080	25
26	ROOF RECOATING			2001	28,450	1,897	15	1,897		17,073	26
27	CARPET SPECIAL CARE UNIT			2001	1,780	178	10	178		1,602	27
28	CONCRETE WORK			2001	1,900	95	20	95		855	28
29	REMODEL 8 ROOMS			2001	11,757	784	15	784		7,056	29
30	FENCING			2001	877	85	10	85		877	30
31	POWER DOOR, RAILING, FIRE WALL			2000	1,903	193	10	193		1,903	31
32	FIRE WALL			2000	21,922	1,138	20	1,138		11,380	32
33	OXYGEN ROOM AND DAMPERS			2000	4,990	250	20	250		2,878	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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DUCT DETECTORS	2000	$ 2,285	$ 224	10	$ 224	$	$ 2,285	37
38	EMERGENCY LIGHTING	2000	2,119	211	10	211		2,119	38
39	SMOKE FIRE DAMPERS	2000	1,300	130	10	130		1,300	39
40	EMERGENCY LIGHTING	2000	801	81	10	81		801	40
41	ALARM SYSTEMS, ROOF REPAIRS	1999	17,250	1,150	15	1,150		12,510	41
42	LAUNDRY REMODEL	1997	13,967	931	15	931		12,103	42
43	CARPETING	1996	1,183	79	15	79		1,106	43
44	VENTILIATION	1996	1,154	77	15	77		1,078	44
45	NURSING CABINETS	1997	9,378	625	15	625		8,125	45
46	STORAGE ROOM	1995	1,662	108	15	108		1,662	46
47	ELECTRIC DOORS	1994	2,867	191	15	191		3,056	47
48	ROOF REPAIRS	1991	82,210	4,101	20	4,101		82,210	48
49	GARAGE	1990	31,318	1,044	30	1,044		20,880	49
50	PARKING LOT PAVING AND GRADING	1990	11,517	573	20	573		11,517	50
51	SIDEWALK SHELTER FLOOR	1988	3,246	130	25	130		2,889	51
52	GARAGE	1981	26,358	879	30	879		23,733	52
53	BUILDING IMPROVEMENT	1983	2,105	70	30	70		1,890	53
54	BUILDING IMPROVEMENT	1985	1,082	36	30	36		900	54
55	LAND IMPROVEMENT	1979	39,483	1,316	30	1,316		36,822	55
56	BUILDING IMPROVEMENT	1986	75,470	2,516	30	2,516		60,006	56
57	BUILDING IMPROVEMENT	1987	24,843	828	30	828		19,044	57
58	BUILDING IMPROVEMENT	1981	10,159	339	30	339		7,797	58
59	BUILDING IMPROVEMENT	1989	2,280	114	20	114		394	59
60									60
61									61
62	KEY PADS & SMOKE DETE 4 CORSYSTEMS	2007	21,244	2,124	10	2,124		6,464	62
63	COPPER BLADE, SOUND SYSTEM	2008	3,935	787	5	787		1,574	63
64	CONLEOM FLOORING, TABLE	2008	3,027	303	10	303		606	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,119,905	$ 91,607		$ 91,607	$	$ 1,890,081	70

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,119,905	$ 91,607		$ 91,607	$	$ 1,890,081	1
2									2
3	WEST WING RENOVATION -								3
4	LABOR	2009	87,631	5,842	15	5,842		5,842	4
5	ELECTRICAL	2009	13,837	922	15	922		922	5
6	CONCRETE	2009	5,350	357	15	357		357	6
7	BUILDING MATERIALS -								7
8	DRYWALL, LUMBER, NAILS, SCREWS	2009	60,358	4,024	15	4,024		4,024	8
9	ARCHITECT	2009	1,109	74	15	74		74	9
10	CLOTHES CLOSET	2009	1,850	123	15	123		123	10
11	BEDS	2009	3,371	225	15	225		225	11
12	DRESSERS	2009	800	53	15	53		53	12
13	CARPET	2009	15,052	1,003	15	1,003		1,003	13
14	PLUMBING	2009	8,863	591	15	591		591	14
15	ROOM LIGHTS	2009	774	52	15	52		52	15
16	PAINT FOR ROOMS	2009	2,266	151	15	151		151	16
17	SPRINLKER SYSTEM	2009	21,300	1,420	15	1,420		1,420	17
18	AIR CONCONDITIONING UNITS	2009	8,563	571	15	571		571	18
19	SIGNS	2009	4,713	314	15	314		314	19
20									20
21									21
22									22
23	BOILER	2010	32,053	1,469	20	1,469		1,469	23
24	FIRE PANEL	2010	31,611	790	20	790		790	24
25	FIRE DOORS	2010	1,687	35	20	35		35	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,421,093	$ 109,623		$ 109,623	$	$ 1,908,097	34

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

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	$ 236,114	$ 20,102	$ 20,102	$	8-15	$ 189,279	71
72	Current Year Purchases	23,463	1,598	1,598		8-15	1,598	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 259,577	$ 21,700	$ 21,700	$		$ 190,877	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	PATIENT TRANSPORT	2003 FORD VAN	2009	$ 4,995	$ 999	$ 999	$	5	$ 999	76
77										77
78										78
79										79
80	TOTALS			$ 4,995	$ 999	$ 999	$		$ 999	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)	$ 3,758,423	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,322	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,322	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)	$ 2,099,973	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	1993-1994 (4) COTTAGES	$ 462,520	$ 14,126	$ 254,228	86
87	1982 MEDICAL CLINIC	171,665	5,793	159,955	87
88					88
89					89
90					90
91	TOTALS	$ 634,185	$ 19,919	$ 414,183	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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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.

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-A3	hrs	$	1,425	$ 85,491	$	1,425	$ 85,491	1
2	Licensed Speech and Language Development Therapist	10-A3	hrs		118	10,565		118	10,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-A3	hrs		3,220	138,121	303	3,220	138,424	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			$	4,763	$ 234,177	$ 303	4,763	$ 234,480	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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/10 (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	$ 314,563	$	1
2	Cash-Patient Deposits	2,515		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	348,503		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,012		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)**	$ 666,593	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	72,758		13
14	Buildings, at Historical Cost	4,060,273		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	259,577		16
17	Accumulated Depreciation (book methods)	(2,514,156)		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)**	$ 1,878,452	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,545,045	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 507,979	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,930		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,660		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,909		32
33	Accrued Interest Payable	3,310		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)**	$ 661,788	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	176,889		39
40	Mortgage Payable	1,311,422		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME	23,538		43
44	DUE INTERNAL REVENUE SERVICE	329,497		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,841,346	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,503,134	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 41,911	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,545,045	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (103,489)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (103,489)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,400	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)**	$ 145,400	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)**	$ 41,911	24 *

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

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,533,292	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,533,292	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	9,624	5
6	Therapy	128,799	6
7	Oxygen	218	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 138,641	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	796	12
13	Barber and Beauty Care	16,030	13
14	Non-Patient Meals	8,132	14
15	Telephone, Television and Radio	471	15
16	Rental of Facility Space	65,150	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	309	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,154	21
22	Laundry	2,727	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 97,769	23
	D. Non-Operating Revenue		
24	Contributions	10,469	24
25	Interest and Other Investment Income***	344	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,813	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	GAIN ON SALE OF ASSETS	8,204	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,204	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,788,719	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	710,721	31
32	Health Care	1,903,124	32
33	General Administration	726,540	33
	B. Capital Expense		
34	Ownership	286,924	34
	C. Ancillary Expense		
35	Special Cost Centers	16,010	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,643,319	40
41	**Income before Income Taxes (line 30 minus line 40)****	145,400	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 145,400	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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,079	2,079	$ 55,614	$ 26.75	1
2	Assistant Director of Nursing	1,951	1,951	47,315	24.25	2
3	Registered Nurses	9,151	9,151	199,850	21.84	3
4	Licensed Practical Nurses	21,163	21,163	319,555	15.10	4
5	CNAs & Orderlies	55,104	55,104	523,487	9.50	5
6	CNA Trainees	10,163	10,163	88,922	8.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,028	1,028	10,771	10.48	8
9	Activity Director	1,806	1,806	17,160	9.50	9
10	Activity Assistants	8,795	8,795	72,562	8.25	10
11	Social Service Workers	3,740	3,740	46,749	12.50	11
12	Dietician					12
13	Food Service Supervisor	2,388	2,388	40,598	17.00	13
14	Head Cook	4,543	4,543	43,154	9.50	14
15	Cook Helpers/Assistants	2,304	2,304	19,008	8.25	15
16	Dishwashers	12,086	12,086	99,712	8.25	16
17	Maintenance Workers	4,390	4,390	53,077	12.09	17
18	Housekeepers	7,363	7,363	60,746	8.25	18
19	Laundry	9,906	9,906	81,728	8.25	19
20	Administrator	2,087	2,087	65,204	31.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,867	1,867	31,741	17.00	23
24	Clerical	8,146	8,146	113,228	13.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,241	2,241	21,294	9.50	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTY SHOP	1,557	1,557	15,493	9.95	33
34	TOTAL (lines 1 - 33)	173,858	173,858	$ 2,026,968 *	$ 11.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROBYN JOHNSON	ADM	0	$ 65,204
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,204

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
ARNOLDS, BEHRENS, NESBITT	ACCOUNTING	$ 22,387
WMD COMPUTER SERVICES	ACCOUNTING	4,500
OMNI FINANCIAL	TAX	800
DENNIS WOODWORTH	LEGAL	1,221
STAFF, BRENNER, STAFF	LEGAL	4,126
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 33,034

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,528
Unemployment Compensation Insurance	10,866
FICA Taxes	148,503
Employee Health Insurance	11,486
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401G PLAN	9,341
EMPLOYEE LIFE INSURANCE	6,387
EMPLOYEE PHYSICALS	2,747
TOTAL (agree to Schedule V, line 22, col.8)	$ 259,858

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	852
Health Care Worker Background Check	
(Indicate # of checks performed 125)	2,513
Patient Background Checks	1,164
MARKETING	21,846
SUSCRIPTIONS	3,481
DUES	6,809
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,655

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	1,621
Seminar Expense	7,036
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,657

* Attach copy of IMRF notifications

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/09 Ending: 10/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **NHRMA**

(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? **YES** If YES, what is the capacity? **99**

(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 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,607** Line **10-2**

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

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

(9) Are you presently operating under a sublease agreement? YES **XX** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **XX** 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. $ **0**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** 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. $ **6,436**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **ARNOLD, BEHRENS, DETER, GRAY, NESBITT**

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

(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? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.