FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0020925

Facility Name: NORTH ADAMS HOME

Address: 2259 EAST 1100TH ST (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:

XX	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
XX	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DEBORAH HULL **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 11/01/14 to 10/31/15 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) DEBORAH HULL
(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: 11/01/14 Ending: 10/31/15

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 92

	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	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	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	12,619	5,010	2,243	19,872	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,619	5,010	2,243	19,872	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.18%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 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 2,243

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: 10/31/15 Fiscal Year: 10/31/15

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/14 Ending: 10/31/15

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	172,402	5,063	3,825	181,290		181,290		181,290			1
2	Food Purchase		127,246		127,246		127,246		127,246			2
3	Housekeeping	39,409	11,397		50,806		50,806		50,806			3
4	Laundry	65,147	5,124	364	70,635		70,635		70,635			4
5	Heat and Other Utilities			108,590	108,590		108,590	(3,349)	105,241			5
6	Maintenance	50,398	10,249	38,976	99,623		99,623		99,623			6
7	Other (specify):*											7
8	TOTAL General Services	327,356	159,079	151,755	638,190		638,190	(3,349)	634,841			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,177,156	156,935	15,484	1,349,575		1,349,575		1,349,575			10
10a	Therapy		806	214,680	215,486		215,486		215,486			10a
11	Activities	70,759	3,078		73,837		73,837		73,837			11
12	Social Services	53,611	101		53,712		53,712		53,712			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,301,526	160,920	230,164	1,692,610		1,692,610		1,692,610			16
	C. General Administration											
17	Administrative	72,636			72,636		72,636		72,636			17
18	Directors Fees											18
19	Professional Services			16,014	16,014		16,014		16,014			19
20	Dues, Fees, Subscriptions & Promotions			28,266	28,266		28,266		28,266			20
21	Clerical & General Office Expenses	135,406	51,408	165,219	352,033		352,033	(81,633)	270,400			21
22	Employee Benefits & Payroll Taxes			237,976	237,976		237,976		237,976			22
23	Inservice Training & Education			2,877	2,877		2,877		2,877			23
24	Travel and Seminar			1,845	1,845		1,845		1,845			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,693	86,693		86,693		86,693			26
27	Other (specify):*											27
28	TOTAL General Administration	208,042	51,408	538,890	798,340		798,340	(81,633)	716,707			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,836,924	371,407	920,809	3,129,140		3,129,140	(84,982)	3,044,158			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: 11/01/14 Ending: 10/31/15

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			164,917	164,917	(6,616)	158,301		158,301			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,790	73,790		73,790	(12,656)	61,134			32
33	Real Estate Taxes			11,981	11,981		11,981		11,981			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			250,688	250,688	(6,616)	244,072	(12,656)	231,416			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	23,842		7,819	31,661	6,616	38,277		38,277			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	12,820	495		13,315		13,315		13,315			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,008	107,008		107,008		107,008			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	36,662	495	114,827	151,984	6,616	158,600		158,600			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,873,586	371,902	1,286,324	3,531,812		3,531,812	(97,638)	3,434,174			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: 11/01/14 Ending: 10/31/15

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	3,349	LINE 5		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	7,618	LINE 32		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	5,038	LINE 32		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	81,633	LINE 21		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)**	$ 97,638		$	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))**	$ 97,638		37

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

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

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

NORTH ADAMS HOME

ID# 0020925

Report Period Beginning: 11/01/14

Ending: 10/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTH ADAMS HOME # 0020925 **Report Period Beginning:** 11/01/14 **Ending:** 10/31/15

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:** 11/01/14 **Ending:** 10/31/15

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: 11/01/14 Ending: 10/31/15

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

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: 11/01/14 Ending: 10/31/15

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 NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/14 Ending: 10/31/15

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: 11/01/14 Ending: 10/31/15

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: 11/01/14 Ending: 10/31/15

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	1ST MORTGAGE	$6,548.00	10-31-01	$ 2,000,000	$ 631,772	03-04-25	3.1450	$ 21,701	1
2	FIRST BANKERS TRUST		X	2ND MORTGAGE	$6,465.00	05-01-15	900,000	888,429	05-01-35	5.9500	35,191	2
3	FIRST BANKERS TRUST		X	LINE OF CREDIT		02-20-09	275,000	17,000	06-13-16	4.8750	658	3
4	SAV-A-DAY LAUNDRY		X	EQUIPMENT	$211.00	12-15-13	6,950	2,654	12-15-16	6.0000	208	4
5	INTERNAL REVENUE SERVICE		X	TAX						3.0000	7,618	5
	Working Capital											
6	NORTH ADAMS STATE BANK		X	LINE OF CREDIT							494	6
7												7
8												8
9	TOTAL Facility Related				$13,224.00		$ 3,181,950	$ 1,539,855			$ 65,870	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,181,950	$ 1,539,855			$ 65,870	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE 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: 11/01/14 Ending: 10/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	10,627	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.)	$	12,895	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,268	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	9,713	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.	$	11,981	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	12,092	8
	2011	12,510	9
	2012	12,573	10
	2013	12,752	11
	2014	12,895	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTH ADAMS HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT DEBORAH HULL

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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-0708-004-00	COMMERCIAL	$ 12,895.00	$ 12,895.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 12,895.00	$ 12,895.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 11/01/14 Ending: 10/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,952 B. General Construction Type: Exterior BRICK Frame _____ 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).

MEDICAAL CLINIC - 2657 SQ. FT.
COTTAGES -2756 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	LAND	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: 11/01/14 Ending: 10/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	81		1977	1977	$ 735,383	$ 11,880	40	$ 11,880	$	$ 722,663	4
5	1		1986	1986	438,224	14,607	30	14,607		408,996	5
6	10		1990	1990	31,318	1,044	30	1,044		24,968	6
7			1997	1997	1,374,932	34,373	40	34,373		721,161	7
8											8
	Improvement Type**										
9	PTAC HEATING A/C UNIT			2005	965	64	15	64		576	9
10	RESIDENT ROOM GLASS (5)			2004	735	69	10	69	735		10
11	PTAC HEATING A/C UNITS (6)			2004	8,512	567	15	567		6,080	11
12	COMPACTOR ELECTRICAL WIRING			2004	750	75	10	75	750		12
13	WATER SOFTENER ELEMENTS & RESIN			2004	2,438	242	10	242	2,438		13
14	PLUMBING REPLACEMENT DRAIN PIPE			2004	1,000	40	25	40		400	14
15	AIR CURTAIN			2004	578	39	15	39		390	15
16	GENERATOR			2002	18,497	925	20	925		11,100	16
17	WALL PANEL			2004	1,829	182	10	182	1,829		17
18	CONCRETE WORK			2002	937	47	20	47		564	18
19	PARKING LOT LIGHT			2002	788	53	15	53		636	19
20	ROOM REMODEL			2002	9,522	635	15	635		7,620	20
21	ROOF RECOATING			2001	28,450	1,897	15	1,897		24,661	21
22	CONCRETE WORK			2001	1,900	95	20	95		1,235	22
23	REMODEL EIGHT ROOMS			2001	11,757	784	15	784		10,192	23
24	FIRE WALL			2000	21,922	1,096	20	1,096		15,806	24
25	OXYGEN ROOM AND DAMPERS			2000	4,990	250	20	250		3,878	25
26	ALARM SYSTEMS, ROOF REPAIRS			1999	17,250	1,150	15	1,150		17,110	26
27	BUILDING IMPROVEMENT			1983	2,105	5	30	5	2,105		27
28	BUILDING IMPROVEMENT			1985	1,082	36	30	36		1,044	28
29	BUILDING IMPROVEMENT			1986	75,470	2,516	30	2,516		70,070	29
30	BUILDING IMPROVEMENT			1987	24,843	828	30	828		22,356	30
31	BUILDING IMPROVEMENT			1989	2,280	114	20	114		850	31
32	KEY PADS & SMOKE DETE 4 CORSYSTEMS			2007	13,242	1,324	10	1,324		12,806	32
33	BOILDER			11/30/2009	32,053	1,603	20	1,603		6,412	33
34	FIRE PANEL			4/30/2010	31,611	1,581	20	1,581		6,324	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: 11/01/14 Ending: 10/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WEST WING RENOVATION		$	$		$	$	$	37
38	LABOR	2009	87,631	5,842	15	5,842		29,210	38
39	ELECTRICAL	2009	13,837	922	15	922		4,610	39
40	CONCRETE	2009	5,350	357	15	357		1,785	40
41	BUILDING MATERIALS -								41
42	DRYWALL, LUMBER, NAILS	2009	60,358	4,024	15	4,024		20,120	42
43	ARCHITECT	2009	1,109	74	15	74		370	43
44	CLOTHES CLOSET	2009	1,850	123	15	123		615	44
45	CARPET	2009	15,052	1,003	15	1,003		5,015	45
46	PLUMBING	2009	8,863	591	15	591		2,955	46
47	ROOM CALL LIGHTS	2009	774	52	15	52		260	47
48	PAINT FOR ROOMS	2009	2,266	151	15	151		755	48
49	SPRINKLER SYSTEMS	2009	21,300	1,420	15	1,420		7,100	49
50	AIR CONDITIONING UNITS	2009	8,563	571	15	571		2,855	50
51	SIGNS	2009	4,713	314	15	314		1,570	51
52	PLUMBING - WEST WING	11/1/2011	4,795	320	15	320		1,280	52
53	SEAL PARKING LOT	8/1/2011	23,050	4,610	5	4,610		14,983	53
54	PARKING LOT - CONCRETE WORK	8/1/2011	3,400	680	5	680		2,210	54
55	ROOF SKIN	9/30/2012	46,920	3,128	15	3,128		6,517	55
56	SPRINKLER SYSTEM	3/31/2012	41,340	2,756	15	2,756		7,120	56
57	SPRINKLER SYSTEM	5/16/2013	2,975	198	15	198		281	57
58	CARPET	6/27/2013	2,720	181	15	181		257	58
59	CARPET	1/20/2014	3,880	388	10	388		679	59
60	HORTON 7100 EASY ACCESS DOOR	8/7/2015	1,994	50	10	50		50	60
61	UNDERGROUND DRAINAGE IN KITCHEN	9/1/2015	4,950	83	10	83		83	61
62									62
63	FULLY DEPRECIATED		(7,857)						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,255,196	$ 105,959		$ 105,959	$ 7,857	$ 2,208,578	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: 11/01/14 Ending: 10/31/15

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	$ 312,204	$ 34,178	$ 34,178	$	8-15 YRS.	$ 201,951	71
72	Current Year Purchases	19,295	2,928	2,928		8-15 YRS.	2,928	72
73	Fully Depreciated Assets	(8,489)						73
74								74
75	TOTALS	$ 323,010	$ 37,106	$ 37,106	$		$ 204,879	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	PATIENT TRANSPORT	2003 FORD	2009	$ 4,995	$	$	$		$ 4,995	76
77	PATIENT TRANSPORT	2013 FORD	2014	36,753	6,616	6,616		5 YRS	10,475	77
78										78
79										79
80	TOTALS			$ 41,748	$ 6,616	$ 6,616	$		$ 15,470	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)	$ 3,692,712	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 149,681	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,681	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)	$ 2,428,927	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	4- COTTAGES - 1993	$ 482,406	$ 15,236	$ 279,121	86
87	CARPET - 2015	2,842			87
88					88
89					89
90					90
91	TOTALS	$ 485,248	$ 15,236	$ 279,121	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: 11/01/14 Ending: 10/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 11/01/14 Ending: 10/31/15

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: 11/01/14 Ending: 10/31/15

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	412	$ 87,862	$	412	$ 87,862	1
2	Licensed Speech and Language Development Therapist		hrs		119	14,038		119	14,038	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,697	112,781	806	1,697	113,587	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			$	2,228	$ 214,681	$ 806	2,228	$ 215,487	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.

STATE OF ILLINOIS

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11/01/14 Ending: 10/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/15 (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	$ 36,873	$ 36,873	1
2	Cash-Patient Deposits	2,998	2,998	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (15,738))	1,071,350	1,071,350	3
4	Supply Inventory (priced at COST)	7,535	7,535	4
5	Short-Term Investments			5
6	Prepaid Insurance	18,723	18,723	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)**	$ 1,137,479	$ 1,137,479	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	74,484	74,484	13
14	Buildings, at Historical Cost	3,738,719	3,738,719	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	364,758	364,758	16
17	Accumulated Depreciation (book methods)	(2,708,048)	(2,708,048)	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)**	$ 1,469,913	$ 1,469,913	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,607,392	$ 2,607,392	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 98,951	$ 98,951	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,451	1,451	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,688	108,688	30
31	Accrued Taxes Payable (excluding real estate taxes)	86,770	86,770	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,712	9,712	32
33	Accrued Interest Payable	6	6	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)**	$ 305,578	$ 305,578	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,654	19,654	39
40	Mortgage Payable	1,520,200	1,520,200	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME	4,988	4,988	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,544,842	$ 1,544,842	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,850,420	$ 1,850,420	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 756,972	$ 756,972	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,607,392	$ 2,607,392	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 740,640	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 740,640	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	16,332	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)**	$ 16,332	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)**	$ 756,972	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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,445,403	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,445,403	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	9,360	5
6	Therapy		6
7	Oxygen	5,945	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 15,305	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	515	12
13	Barber and Beauty Care	12,080	13
14	Non-Patient Meals	11,110	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	53,053	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	7,300	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 84,058	23
	D. Non-Operating Revenue		
24	Contributions	3,300	24
25	Interest and Other Investment Income***	78	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,378	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,548,144	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	466,733	31
32	Health Care	1,800,332	32
33	General Administration	904,621	33
	B. Capital Expense		
34	Ownership	233,669	34
	C. Ancillary Expense		
35	Special Cost Centers	14,411	35
36	Provider Participation Fee	107,008	36
	D. Other Expenses (specify):		
37	FINES AND PENALTIES	5,038	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,531,812	40
41	**Income before Income Taxes (line 30 minus line 40)****	16,332	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 16,332	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,640,304	44
45	Private Pay - Net Inpatient Revenue	835,651	45
46	Medicare - Net Inpatient Revenue	969,448	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,445,403	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.**

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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	2,112	2,112	$ 63,110	$ 29.88	1
2	Assistant Director of Nursing	2,112	2,112	54,765	25.93	2
3	Registered Nurses	17,959	17,959	437,045	24.34	3
4	Licensed Practical Nurses	11,381	11,381	191,790	16.85	4
5	CNAs & Orderlies	39,225	39,225	430,446	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,165	2,165	27,149	12.54	9
10	Activity Assistants	4,482	4,482	43,610	9.73	10
11	Social Service Workers	3,846	3,846	53,611	13.94	11
12	Dietician					12
13	Food Service Supervisor	2,112	2,112	37,680	17.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,451	4,451	43,714	9.82	15
16	Dishwashers	9,483	9,483	91,008	9.60	16
17	Maintenance Workers	3,784	3,784	50,398	13.32	17
18	Housekeepers	4,487	4,487	39,409	8.78	18
19	Laundry	5,109	5,109	65,147	12.75	19
20	Administrator	2,073	2,073	72,636	35.04	20
21	Assistant Administrator					21
22	Other Administrative	2,098	2,098	32,033	15.27	22
23	Office Manager	2,063	2,063	37,427	18.14	23
24	Clerical	4,838	4,838	65,946	13.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: TRANSPORTATI	2,226	2,226	23,842	10.71	32
33	Other(specify) BEAUTY SHOP	1,213	1,213	12,820	10.57	33
34	TOTAL (lines 1 - 33)	127,219	127,219	$ 1,873,586 *	$ 14.73	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	ADMINISTRATOR		$ 31,443
DEBORAH HULL	ADMINISTRATOR		41,193
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,636

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
TEMPLIN HEALTHCARE	ACCOUNTING	$ 2,014
DENNIS COOK	AUDIT	14,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 16,014

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,511
Unemployment Compensation Insurance	18,491
FICA Taxes	143,245
Employee Health Insurance	13,028
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K PLAN	10,166
EMPLOYEE PHYSICALS	535
TOTAL (agree to Schedule V, line 22, col.8)	$ 237,976

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,377
Health Care Worker Background Check (Indicate # of checks performed 42)	770
Patient Background Checks 39	1,292
MARKETING	14,740
SUBSCRIPTIONS	500
DUES	3,587
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,266

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	132
Seminar Expense	1,713
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,845

**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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,582** 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 **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. $ **107,008**
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. $ **5,435**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **YES**
Firm Name: **DENNIS COOK**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.