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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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:

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 11-01-15 to 10-31-16 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: 11-01-15 Ending: 10-31-16

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	33,672	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	33,672	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	11,971	6,004	2,544	20,519	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,971	6,004	2,544	20,519	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.94%

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 2,544

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: 10-31-16 Fiscal Year: 10-31-16

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11-01-15 Ending: 10-31-16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,051	6,077	1,714	200,842		200,842		200,842			1
2	Food Purchase		137,743		137,743		137,743		137,743			2
3	Housekeeping	43,706	11,489		55,195		55,195		55,195			3
4	Laundry	68,850	6,273		75,123		75,123		75,123			4
5	Heat and Other Utilities			110,152	110,152		110,152	(3,070)	107,082			5
6	Maintenance	75,961	13,017	50,245	139,223		139,223		139,223			6
7	Other (specify):*											7
8	TOTAL General Services	381,568	174,599	162,111	718,278		718,278	(3,070)	715,208			8
	B. Health Care and Programs											
9	Medical Director			4,787	4,787		4,787		4,787			9
10	Nursing and Medical Records	1,209,616	195,812	12,220	1,417,648		1,417,648		1,417,648			10
10a	Therapy			285,578	285,578		285,578		285,578			10a
11	Activities	77,069	2,876		79,945		79,945		79,945			11
12	Social Services	55,161			55,161		55,161		55,161			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,341,846	198,688	302,585	1,843,119		1,843,119		1,843,119			16
	C. General Administration											
17	Administrative	72,863			72,863		72,863		72,863			17
18	Directors Fees											18
19	Professional Services			18,140	18,140		18,140		18,140			19
20	Dues, Fees, Subscriptions & Promotions			37,501	37,501		37,501		37,501			20
21	Clerical & General Office Expenses	138,927	49,497	207,469	395,893		395,893	(122,433)	273,460			21
22	Employee Benefits & Payroll Taxes			286,200	286,200		286,200		286,200			22
23	Inservice Training & Education			4,710	4,710		4,710		4,710			23
24	Travel and Seminar			1,218	1,218		1,218		1,218			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,601	53,601		53,601		53,601			26
27	Other (specify):*											27
28	TOTAL General Administration	211,790	49,497	608,839	870,126		870,126	(122,433)	747,693			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,935,204	422,784	1,073,535	3,431,523		3,431,523	(125,503)	3,306,020			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: 11-01-15 Ending: 10-31-16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			163,545	163,545	(6,616)	156,929		156,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			78,758	78,758		78,758	(5,052)	73,706			32
33	Real Estate Taxes			13,626	13,626		13,626		13,626			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			255,929	255,929	(6,616)	249,313	(5,052)	244,261			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	24,488		3,549	28,037	6,616	34,653		34,653			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	11,940	536		12,476		12,476		12,476			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,107	109,107		109,107		109,107			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	36,428	536	112,656	149,620	6,616	156,236		156,236			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,971,632	423,320	1,442,120	3,837,072		3,837,072	(130,555)	3,706,517			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: 11-01-15 Ending: 10-31-16

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 Reference	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	3,070	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				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	5,052	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	122,433	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)**	$ 130,555		$	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))**	$ 130,555		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.	XX		$ 34,652	LINE 38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops	XX		12,476	LINE 41	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)**			$ 47,128		47

NORTH ADAMS HOME

ID# 0020925

Report Period Beginning: 11-01-15

Ending: 10-31-16

	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:** 11-01-15 **Ending:** 10-31-16

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

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTH ADAMS HOME # 0020925 **Report Period Beginning:** 11-01-15 **Ending:** 10-31-16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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: 11-01-15 Ending: 10-31-16

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: 11-01-15 Ending: 10-31-16

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: 11-01-15 Ending: 10-31-16

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: 11-01-15 Ending: 10-31-16

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: 11-01-15 Ending: 10-31-16

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	$6,548.00	10-31-01	$ 2,000,000	$ 578,410	03-04-25	0.0315	$ 20,035	1
2	FIRST BANKERS TRUST		X	2ND MORTGGE	$6,465.00	05-01-15	900,000	865,926	05-01-35	0.0595	52,575	2
3												3
4												4
5												5
	Working Capital											
6	FIRST BANKERS TRUST		X	LINE OF CREDIT		02-20-09	275,000	50,000	06-13-17	0.0438	1,317	6
7	SAV-A-DAY LAUNDRY		X	EQUIPMENT	$211.00	12-15-13	6,950	418	12-15-16	0.0600	91	7
8												8
9	TOTAL Facility Related				$13,224.00		$ 3,181,950	$ 1,494,754			$ 74,018	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	$ 1,494,754			$ 74,018	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: 11-01-15 Ending: 10-31-16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 9,713	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.)		$ 12,730	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,017	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,609	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.		$ 13,626	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	12,510	8
	2012	12,573	9
	2013	12,752	10
	2014	12,895	11
	2015	12,730	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-0-0708-004-00	COMMERCIAL	$ 12,730.00	$ 12,730.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 12,730.00	$ 12,730.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 11-01-15 Ending: 10-31-16

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).

MEDICAL 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: 11-01-15 Ending: 10-31-16

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	$ 761,833	$ 10,264	40	$ 10,264	$	$ 745,029	4
5	1		1986	1986	438,224	14,607	30	14,607	438,224		5
6	10		1990	1990	31,318	1,044	30	1,044		26,012	6
7			1997	1997	1,380,056	34,501	40	34,501		755,662	7
8											8
	Improvement Type**										
9	PTAC HEATING A/C UNIT			2005	965	64	15	64		640	9
10	PTAC HEATING A/C UNITS (6)			2004	8,512	567	15	567		6,647	10
11	PLUMBING REPLACEMENT DRAIN PIPE			2004	1,000	40	25	40		440	11
12	AIR CURTAIN			2004	578	39	15	39		429	12
13	GENERATOR			2002	18,497	925	20	925		12,025	13
14	CONCRETE WORK			2002	937	47	20	47		611	14
15	PARKING LOT LIGHT			2002	788	53	15	53		689	15
16	ROOM REMODEL			2002	9,522	635	15	635		8,255	16
17	ROOF RECOATING			2001	28,450	1,897	15	1,897	28,450		17
18	CONCRETE WORK			2001	1,900	95	20	95		1,330	18
19	REMODEL 8 ROOMS			2001	11,757	784	15	784		10,976	19
20	FIRE WALL			2000	21,922	1,096	20	1,096		16,902	20
21	OXYGEN ROOM AND DAMPERS			2000	4,990	250	20	250		4,128	21
22	ALARM SYSTEMS, ROOF REPAIRS			1999	17,250	1,150	15	1,150	17,250		22
23	BUILDING IMPROVEMENT			1985	1,082	36	30	36	1,082		23
24	BUILDING IMPROVEMENT			1986	75,470	2,516	30	2,516		72,586	24
25	BUILDING IMPROVEMENT			1987	24,843	828	30	828		23,184	25
26	BUILDING IMPROVEMENT			1989	2,280	114	20	114		964	26
27	KEY PADS & SMOKE DETE 4 CORSYSTEMS			2007	13,242	436	10	436	13,242		27
28	BOILER			2009	32,053	1,603	20	1,603		8,015	28
29	FIRE PANEL			2010	31,611	1,581	20	1,581		7,905	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11-01-15 Ending: 10-31-16

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		35,052	38
39	ELECTRICAL	2009	13,837	922	15	922		5,532	39
40	CONCRETE	2009	5,350	357	15	357		2,142	40
41	BUILDING MATERIALS -								41
42	DRYWALL, LUMBER, NAILS, SCREWS	2009	60,358	4,024	15	4,024		24,144	42
43	ARCHITECT	2009	1,109	74	15	74		444	43
44	CLOTHES CLOSET	2009	1,850	123	15	123		738	44
45	CARPET	2009	15,052	1,003	15	1,003		6,018	45
46	PLUMBING	2009	8,863	591	15	591		3,546	46
47	ROOM CALL LIGHTS	2009	774	52	15	52		312	47
48	PAINT FOR ROOMS	2009	2,266	151	15	151		906	48
49	SPRINKLER SYSTEM	2009	21,300	1,420	15	1,420		8,520	49
50	AIR CONDITIONING UNITS	2009	8,563	571	15	571		3,426	50
51	SIGNS	2009	4,713	314	15	314		1,884	51
52	PLUMBING - WEST WING	2011	4,795	320	15	320		1,600	52
53	SEAL PARKING LOT	2011	23,050	4,610	5	4,610	23,050		53
54	PARKING LOT - CONCRETE WORK	2011	3,400	680	5	680	3,400		54
55	ROOF SKIN	2012	46,920	3,128	15	3,128		9,645	55
56	SPRINKLER SYSTEM	2012	41,340	2,756	15	2,756		9,876	56
57	SPRINKLER SYSTEM	2013	2,975	198	15	198		479	57
58	CARPET	2013	2,720	181	15	181		438	58
59	CARPET	2014	3,880	388	10	388		1,067	59
60	HORTON 7100 EASY ACCESS DOOR	2015	1,994	199	10	199		249	60
61	UNDERGROUND DRAINAGE IN KITCHEN	2015	4,950	495	10	495		578	61
62	VINYL REPLACMENT WINDOWS	2016	1,586	132	10	132		132	62
63									63
64	ELECTRICAL WIRING FOR GENERATOR	2016	31,746	529	10	529		529	64
65									65
66	FULLY DEPRECIATED		(524,698)						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,795,404	$ 104,232		$ 104,232	$ 524,698	$ 1,819,686	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: 11-01-15 Ending: 10-31-16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,795,404	$ 104,232		$ 104,232	$	$ 1,819,686	1
2									2
3									3
4	SHOWER ROOM -								4
5	LABOR - CARPENTER	4/1/2016	6,210	363		363		363	5
6	MATERIALS -								6
7	CORNER GUARD FOR SHOWER	4/1/2016	109	6		6		6	7
8	CABINETS	4/1/2016	642	37		37		37	8
9	ELECTRICAL	4/1/2016	115	7		7		7	9
10	PAINT AND GLUE	4/1/2016	99	6		6		6	10
11	STEEL STUDS	4/1/2016	116	7		7		7	11
12	LUMBER	4/1/2016	473	28		28		28	12
13	TILE AND CEMENT BOARD	4/1/2016	268	16		16		16	13
14	PLUMBING	4/1/2016	158	9		9		9	14
15									15
16	RESIDENT WINDOW								16
17	LABOR - CARPENTER	4/1/2016	1,564	91		91		91	17
18	WINDOW	4/1/2016	1,376	80		80		80	18
19									19
20	WASHER DRYER ROOM								20
21	LABOR - CARPENTER	4/1/2016	2,990	174		174		174	21
22	DOOR	4/1/2016	488	28		28		28	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,810,012	$ 105,084		$ 105,084	$	$ 1,820,538	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: 11-01-15 Ending: 10-31-16

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	$ 323,010	$ 33,822	$ 33,822	$	8-15 YRS	$ 147,444	71
72	Current Year Purchases	23,629	2,313	2,313		8-15 YEARS	2,313	72
73	Fully Depreciated Assets	(91,258)						73
74								74
75	TOTALS	$ 255,381	$ 36,135	$ 36,135	$		$ 149,757	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.	17,090	77
78										78
79										79
80	TOTALS			$ 41,748	$ 6,616	$ 6,616	$		$ 22,085	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)	$ 3,179,899	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 147,835	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 147,835	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)	$ 1,992,380	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	$ 488,178	$ 15,711	$ 294,832	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 488,178	$ 15,711	$ 294,832	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: 11-01-15 Ending: 10-31-16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 11-01-15 Ending: 10-31-16

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.

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	10-3B	hrs	$	6,682	$ 122,956	$	6,682	$ 122,956	1
2	Licensed Speech and Language Development Therapist	10-3B	hrs		275	17,134		275	17,134	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3B	hrs		7,793	145,487		7,793	145,487	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	14,750	$ 285,577	$	14,750	$ 285,577	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:** 11-01-15 **Ending:** 10-31-16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 10-31-16 **(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	$ 174,795	$ 174,795	1
2	Cash-Patient Deposits	3,517	3,517	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,494)	985,417	985,417	3
4	Supply Inventory (priced at COST)	6,653	6,653	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,301	7,301	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)**	$ 1,177,683	$ 1,177,683	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	3,296,465	3,296,465	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	297,129	297,129	16
17	Accumulated Depreciation (book methods)	(2,287,211)	(2,287,211)	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)**	$ 1,380,867	$ 1,380,867	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,558,550	$ 2,558,550	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 96,970	$ 96,970	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,969	1,969	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,718	116,718	30
31	Accrued Taxes Payable (excluding real estate taxes)	114,921	114,921	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,609	10,609	32
33	Accrued Interest Payable	5,442	5,442	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)**	$ 346,629	$ 346,629	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	50,418	50,418	39
40	Mortgage Payable	1,444,336	1,444,336	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME	1,838	1,838	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,496,592	$ 1,496,592	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,843,221	$ 1,843,221	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 715,329	$ 715,329	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,558,550	$ 2,558,550	48

***(See instructions.)**

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11-01-15 Ending: 10-31-16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 756,972	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 756,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(41,643)	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)**	$ (41,643)	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)**	$ 715,329	24 *

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11-01-15 Ending: 10-31-16

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	$ 3,680,144	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,680,144	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	9,999	5
6	Therapy		6
7	Oxygen	3,795	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 13,794	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	336	12
13	Barber and Beauty Care	12,911	13
14	Non-Patient Meals	12,650	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	57,413	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	2,524	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 85,834	23
	D. Non-Operating Revenue		
24	Contributions	15,606	24
25	Interest and Other Investment Income***	50	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,656	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)**	$ 3,795,428	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	626,422	31
32	Health Care	2,002,576	32
33	General Administration	842,783	33
	B. Capital Expense		
34	Ownership	237,251	34
	C. Ancillary Expense		
35	Special Cost Centers	13,880	35
36	Provider Participation Fee	109,107	36
	D. Other Expenses (specify):		
37	FINES AND PENALTIES	5,052	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,837,071	40
41	**Income before Income Taxes (line 30 minus line 40)****	(41,643)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (41,643)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,382,866	44
45	Private Pay - Net Inpatient Revenue	1,121,504	45
46	Medicare - Net Inpatient Revenue	1,175,774	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,680,144	49

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

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

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

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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11-01-15 Ending: 10-31-16

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	2,085	2,085	$ 64,922	$ 31.14	1
2	Assistant Director of Nursing	2,085	2,085	56,342	27.02	2
3	Registered Nurses	19,016	19,016	458,158	24.09	3
4	Licensed Practical Nurses	14,498	14,498	236,181	16.29	4
5	CNAs & Orderlies	36,838	36,838	394,013	10.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,143	2,143	27,378	12.78	9
10	Activity Assistants	5,235	5,235	49,691	9.49	10
11	Social Service Workers	4,015	4,015	55,161	13.74	11
12	Dietician					12
13	Food Service Supervisor	2,126	2,126	39,658	18.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,642	2,642	24,410	9.24	15
16	Dishwashers	13,719	13,719	128,983	9.40	16
17	Maintenance Workers	5,344	5,344	75,961	14.21	17
18	Housekeepers	4,881	4,881	43,706	8.95	18
19	Laundry	5,299	5,299	68,850	12.99	19
20	Administrator	2,085	2,085	72,863	34.95	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	36,306	17.45	22
23	Office Manager	1,978	1,978	38,875	19.65	23
24	Clerical	4,791	4,791	63,746	13.31	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	2,242	2,242	24,488	10.92	32
33	Other(specify) BEAUTY SHOP	1,103	1,103	11,940	10.83	33
34	TOTAL (lines 1 - 33)	134,205	134,205	$ 1,971,632 *	$ 14.69	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	112	$ 6,036	1-3	35
36	Medical Director	21	4,787	9-3	36
37	Medical Records Consultant	26	1,888	10-3	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)	159	$ 12,711		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

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11-01-15 Ending: 10-31-16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEBORAH HULL	ADMINISTRATOR	0	$ 72,863
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,863

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	$ 2,090
DENNIS COOK	ACCOUNTING	14,000
STAFF, BRENNER, STAFF	LEGAL	2,050
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 18,140

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,835
Unemployment Compensation Insurance	12,193
FICA Taxes	150,039
Employee Health Insurance	52,442
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K PLAN	9,646
EMPLOYEE PHYSICALS	45
TOTAL (agree to Schedule V, line 22, col.8)	$ 286,200

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	$ 3,980
Advertising: Employee Recruitment	12,221
Health Care Worker Background Check (Indicate # of checks performed 16)	655
Patient Background Checks 83	1,328
MARKEING	11,790
SUBSCRIPTIONS	243
DUES	7,284
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,501

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	49
Seminar Expense	1,169
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,218

**See instructions.

Facility Name & ID Number NORTH ADAMS HOME # 0020925 Report Period Beginning: 11-01-15 Ending: 10-31-16

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. **ILLINOIS HEALTH CARE (IHCA) $ 5580.00**

(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. $ **13,801** 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. $ **109,107**
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. $ **576**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **DENNIS KOCH**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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