

		FOR OHF USE				

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**2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0020925</u></p> <p><b>Facility Name:</b> <u>North Adams Home</u></p> <p><b>Address:</b> <u>Box 100</u> <u>Mendon</u> <u>IL</u> Number City Zip Code</p> <p><b>County:</b> <u>Adams</u></p> <p><b>Telephone Number:</b> <u>217-936-2137</u> Fax # ( )</p> <p><b>IDPA ID Number:</b> <u>37-0978651001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>10/16/77</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 c 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b> Name: <u>James G. Hull</u> Telephone Number: <u>217-228-1950</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 c 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>11/01/01</u> to <u>10/31/02</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1155 803 1291 820"></td> <td data-bbox="1291 803 1950 868">(Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 950">(Print Name and Title) <u>James G. Hull</u> <u>Vice President</u></td> </tr> <tr> <td data-bbox="1155 950 1291 1031"></td> <td data-bbox="1291 950 1950 1015">(Firm Name &amp; Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u></td> </tr> <tr> <td data-bbox="1155 1015 1291 1031"></td> <td data-bbox="1291 1015 1950 1031">(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>James G. Hull</u> <u>Vice President</u>		(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u>		(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>
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Facility Name & ID Number North Adams Home

# 0020925 Report Period Beginning: 11/01/01 Ending: 10/31/02

**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 05/16/2002

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	109	40,595	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	115	TOTALS	109	40,595	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other		Total
		8	SNF	2,368		949
9	SNF/PED					9
10	ICF	21,251	12,403		33,654	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,619	13,352	26	36,997	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.14%

D. How many bed-hold days during this year were paid by Public Aid? 50 (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)  
Adult Day Care, Outpatient, P.T.

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/16/77

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 7 and days of care provided 26

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 10/31/02 Fiscal Year: 10/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/01 Ending: 10/31/02

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	204,448	14,183	6,820	225,451		225,451		225,451		1
2	Food Purchase		162,538		162,538		162,538	(6,536)	156,002		2
3	Housekeeping	72,929	19,757		92,686		92,686		92,686		3
4	Laundry	105,107	10,434		115,541	384	115,925		115,925		4
5	Heat and Other Utilities			101,103	101,103		101,103		101,103		5
6	Maintenance	64,080	23,427	68,108	155,615	202	155,817		155,817		6
7	Other (specify):*			10,434	10,434		10,434	7	10,441		7
8	<b>TOTAL General Services</b>	<b>446,564</b>	<b>230,339</b>	<b>186,465</b>	<b>863,368</b>	<b>586</b>	<b>863,954</b>	<b>(6,529)</b>	<b>857,425</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,373,360	71,133	19,239	1,463,732		1,463,732	(1,375)	1,462,357		10
10a	Therapy	73,045	1,882	9,630	84,557		84,557	(270)	84,287		10a
11	Activities	80,465	10,915		91,380		91,380	(26)	91,354		11
12	Social Services	38,276	278	6,400	44,954		44,954		44,954		12
13	Nurse Aide Training		314	1,402	1,716		1,716		1,716		13
14	Program Transportation			1,650	1,650		1,650		1,650		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,565,146</b>	<b>84,522</b>	<b>47,921</b>	<b>1,697,589</b>		<b>1,697,589</b>	<b>(1,671)</b>	<b>1,695,918</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	95,840			95,840		95,840		95,840		17
18	Directors Fees										18
19	Professional Services			60,252	60,252	(252)	60,000		60,000		19
20	Dues, Fees, Subscriptions & Promotions			84,495	84,495		84,495	(46,423)	38,072		20
21	Clerical & General Office Expenses	80,222	50,397		130,619		130,619	(226)	130,393		21
22	Employee Benefits & Payroll Taxes			338,688	338,688		338,688		338,688		22
23	Inservice Training & Education			6,697	6,697		6,697		6,697		23
24	Travel and Seminar			11,068	11,068		11,068	(150)	10,918		24
25	Other Admin. Staff Transportation			1,774	1,774		1,774		1,774		25
26	Insurance-Prop.Liab.Malpractice			60,809	60,809		60,809		60,809		26
27	Other (specify):*			425	425		425	(425)			27
28	<b>TOTAL General Administration</b>	<b>176,062</b>	<b>50,397</b>	<b>564,208</b>	<b>790,667</b>	<b>(252)</b>	<b>790,415</b>	<b>(47,224)</b>	<b>743,191</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,187,772</b>	<b>365,258</b>	<b>798,594</b>	<b>3,351,624</b>	<b>334</b>	<b>3,351,958</b>	<b>(55,424)</b>	<b>3,296,534</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

North Adams Home

#0020925

Report Period Beginning:

11/01/01

Ending:

10/31/02

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation				178,299		178,299	(246)	178,053			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,953	128,953		128,953	(19,158)	109,795			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,079	1,079		1,079		1,079			35
36	Other (specify):*			8,345	8,345	(334)	8,011	(8,011)				36
37	<b>TOTAL Ownership</b>			138,377	316,676	(334)	316,342	(27,415)	288,927			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			3,242	3,242		3,242		3,242			38
39	Ancillary Service Centers		95,895	3,958	99,853		99,853		99,853			39
40	Barber and Beauty Shops		974	18,413	19,387		19,387		19,387			40
41	Coffee and Gift Shops		9,896		9,896		9,896		9,896			41
42	Provider Participation Fee			61,442	61,442		61,442		61,442			42
43	Other (specify):*			432	432		432	(432)				43
44	<b>TOTAL Special Cost Centers</b>		106,765	87,487	194,252		194,252	(432)	193,820			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,187,772	472,023	1,024,458	3,862,552		3,862,552	(83,271)	3,779,281			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (250)	10	\$	1
2	Other Care for Outpatients	(270)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,749)	2		4
5	Telephone, TV & Radio in Resident Rooms	(216)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	7	7		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(246)	30		9
10	Interest and Other Investment Income	(19,158)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,787)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(432)	43		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	(3,773)	36		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(425)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(46,423)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule pg 5A	(5,549)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (83,271)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (83,271)		37

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

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

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

North Adams Home

ID# 0020925

Report Period Beginning: 11/01/01

Ending: 10/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Pharmacy 3rd Party Revenue	\$ (1,125)	10	1
2	Activities Program Income	(26)	11	2
3	Miscellaneous Exp.	(45)	36	3
4	Badge Replacement Income	(10)	21	4
5	Loan Origination Fees	(4,193)	36	5
6	Next Year expenses	(150)	24	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
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26				26
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29				29
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31				31
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,549)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Adams Home

# 0020925

Report Period Beginning:

11/01/01

Ending:

10/31/02

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)	
<b>A. General Services</b>														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,536)	0	0	0	0	0	0	0	0	0	0	(6,536)	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):*	7	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,529)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,529)</b>	<b>8</b>
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,375)	0	0	0	0	0	0	0	0	0	0	(1,375)	10
10a	Therapy	(270)	0	0	0	0	0	0	0	0	0	0	(270)	10a
11	Activities	(26)	0	0	0	0	0	0	0	0	0	0	(26)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>(1,671)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,671)</b>	<b>16</b>
<b>C. General Administration</b>														
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	(46,423)	0	0	0	0	0	0	0	0	0	0	(46,423)	20
21	Clerical & General Office Expenses	(226)	0	0	0	0	0	0	0	0	0	0	(226)	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	(150)	0	0	0	0	0	0	0	0	0	0	(150)	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):*	(425)	0	0	0	0	0	0	0	0	0	0	(425)	27
28	<b>TOTAL General Administration</b>	<b>(47,224)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(47,224)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(55,424)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(55,424)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Adams Home

# 0020925

Report Period Beginning:

11/01/01

Ending:

10/31/02

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(246)	0	0	0	0	0	0	0	0	0	0	(246) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(19,158)	0	0	0	0	0	0	0	0	0	0	(19,158) 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):*	(8,011)	0	0	0	0	0	0	0	0	0	0	(8,011) 36
37	<b>TOTAL Ownership</b>	<b>(27,415)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(27,415) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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):*	(432)	0	0	0	0	0	0	0	0	0	0	(432) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(432)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(432) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(83,271)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(83,271) 45</b>

Facility Name & ID Number North Adams Home

# 0020925

Report Period Beginning: 11/01/01

Ending: 10/31/02

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	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: 11/01/01 Ending: 10/31/02

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number North Adams Home

# 0020925 Report Period Beginning: 11/01/01

Ending: 10/31/02

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/01 Ending: 10/31/02

## 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	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	The Manifest Group		X	Equipment Purchase	\$503.25	05/07/01	\$ 14,621	\$ 8,498	06/07/04	14.5000	\$ 1,589	1
2	Caterpillar		X	Generator	\$454.00	01/11/02	12,723	9,818	1/11/05	7.9000	678	2
3	First Banker's Trust		X	Mortgage	\$17,461.00	10/23/01	1,466,855	1,348,409	02/23/11	6.2196	89,292	3
4	North Adams State Bank		X	Cash Flow Payoff	\$3,248.55	03/16/01	250,000	198,385	03/31/04	9.0000	17,558	4
5	Union Bank		X	Cash Flow	Interst	10/23/02	75,100	75,100	11/22/02	12.5000	295	5
	<b>Working Capital</b>											
6	Union Bank		X	Cash Flow	Interest	04/08/02	241,000	329,095	04/08/03	Various	11,267	6
7	First Banker's Trust		X	Cash Flow	Interest	03/16/01	150,000		03/16/02	5.5000	2,969	7
8	North Adams State Bank		X	Cash Flow	Interest	04/08/02	100,000	100,000	04/15/03	9.0000	5,305	8
9	TOTAL Facility Related				\$21,666.80		\$ 2,310,299	\$ 2,069,305			\$ 128,953	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,310,299	\$ 2,069,305			\$ 128,953	15

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

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME North Adams Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0020925

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

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

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

Enter the tax index number and real estate tax assessed for 2001 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 2001

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

**B. Real Estate Tax Cost Allocation:**

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

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

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name &amp; ID Number North Adams Home

# 0020925 Report Period Beginning:

11/01/01 Ending:

10/31/02

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,950 B. General Construction Type: Exterior Brick Frame Fire Restistant Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

North Adams Home, Inc., Medical Clinic, 2567 Sq FtNorth Adams Home, Inc., Cottages, 2756 Sq FtF. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	435,600	1975	\$ 22,893	1
2					2
3	TOTALS	435,600		\$ 22,893	3

Facility Name &amp; ID Number North Adams Home

# 0020925

Report Period Beginning:

11/01/01

Ending:

10/31/02

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	88	1977	1977	\$ 1,036,037	\$ 25,944	40	\$ 25,901	\$ (43)	\$ 646,863	4
5	1	1978	1978	2,633		10			2,633	5
6	10	1986	1986	438,224	14,673	30	14,607	(66)	237,694	6
7	10	1997	1997	1,374,932	34,442	40	34,373	(69)	191,173	7
8										8
<b>Improvement Type**</b>										
9	Garage		1981	26,358					26,245	9
10	Building Improvement		1979	1,158					1,158	10
11	Building Improvement		1980	187					187	11
12	Building Improvement		1981	121					121	12
13	Building Improvement		1983	2,105					2,105	13
14	Building Improvement		1985	1,082					1,082	14
15	Land Improvement		1977	6,339					6,339	15
16	Land Improvement		1978	3,756					3,756	16
17	Land Improvement		1979	15,608					15,608	17
18	Land Improvement		1980	1,556					1,556	18
19	Land Improvement		1982	337					337	19
20	Land Improvement		1983	11,703					11,703	20
21	Land Improvement		1985	2,618					2,618	21
22	Land Improvement (IDPA)		1986	7,661					7,661	22
23	Generator		1979	11,412					11,412	23
24	Intercom System		1980	1,319					1,319	24
25	Fixed Equipment		1982	29,082					29,082	25
26	Building Improvement		1986	28,142	160	15	160		28,142	26
27	Building Improvement		1986	47,328	268	15	268		47,328	27
28	Building Improvement		1987	9,880	280	15	280		9,824	28
29	Building Improvement		1987	4,145	141	15	141		4,122	29
30	Building Improvement		1987	6,319	215	15	215		6,284	30
31	Building Improvement		1987	3,244	147	15	147		3,225	31
32	Land Improvement (IDPA)		1986	10,159					10,159	32
33	Land Improvement (IDPA)		1987	1,192					1,192	33
34	Land Improvement		1987	1,255					1,255	34
35	Wall Carpet		1988	12,374	838	15	825	(13)	12,095	35
36	Cabinets/doors		1988	5,316	266	20	266		3,788	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 &amp; ID Number North Adams Home

# 0020925

Report Period Beginning:

11/01/01

Ending:

10/31/02

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Sprinklers	1988	\$ 663	\$ 27	25	\$ 27	\$	\$ 378	37
38	Exhaust Fan/Door Locks	1988	2,151	143	15	143		2,020	38
39	Sidewalk & Shelter Floor	1988	2,583					2,583	39
40	Land Improvements	1988	3,052					3,052	40
41	Patient Sensor System	1989	3,964					3,964	41
42	Dining Room Remodel	1989	3,943	263	15	263		3,483	42
43	Garage	1990	31,318	1,044	30	1,044		12,614	43
44	Parking Lot Paving	1990	10,500					10,500	44
45	Parking Lot Grading	1990	1,017					1,009	45
46	Roof repairs	1990	1,372	91	15	91		1,090	46
47	Land Improvements	1993	760	77	10	76	(1)	747	47
48	Roof	1991	82,210	4,128	20	4,111	(17)	47,125	48
49	Patio	1994	15,076	1,508	10	1,508		12,315	49
50	Electric Doors	1994	2,867	191	15	191		1,513	50
51	Storage Room	1995	1,662	111	15	111		831	51
52	Patient Sensor System	1996	2,340	236	10	234	(2)	1,552	52
53	Landscaping	1996	776	78	10	78		482	53
54	Carpet	1996	1,183	79	15	79		495	54
55	Ventilation	1996	1,154	77	15	77		464	55
56	Nursing Cabinets	1996	9,378	629	15	625	(4)	3,770	56
57	New Addition - Garden	1997	25,624	2,586	10	2,562	(24)	14,420	57
58	New Addition - Egress	1997	4,431	447	10	443	(4)	2,493	58
59	Laundry Remodel	1997	13,967	936	15	931	(5)	4,759	59
60	Re-roof	1998	5,232	349	15	349		1,555	60
61	Alarm System	1999	2,466	164	15	164		575	61
62	Roof repairs	1999	11,000	733	15	733		2,567	62
63	Landscaping	1999	992	99	10	99		314	63
64	Shower Remodel	1999	2,792	141	20	140	(1)	387	64
65	Power Door (scu)	2000	1,233	123	10	123		319	65
66	New Railing	2000	670	67	10	67		167	66
67	Fire Wall	2000	21,922	1,096	20	1,096		2,466	67
68	Oxygen Room	2000	2,409	120	20	120		271	68
69	Dampers	2000	2,581	172	15	172		387	69
70	TOTAL (lines 4 thru 69)		\$ 3,376,870	\$ 93,089		\$ 92,840	\$ (249)	\$ 1,468,733	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:

11/01/01

Ending:

10/31/02

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,376,870	\$ 93,089		\$ 92,840	\$ (249)	\$ 1,468,733	1
2	Duct Detectors	2000	2,285	228	10	228		514	2
3	Emergency Lighting	2000	2,119	212	10	212		477	3
4	Smoke/Fire Dampers	2000	1,300	130	10	130		282	4
5	Emergency Lighting	2000	801	80	10	80		174	5
6	Roof Recoating	2001	28,450	1,897	15	1,897		2,529	6
7	Carpet for special care unit	2001	1,780	181	10	178	(3)	226	7
8	Concrete to lift room	2001	1,900	95	20	95		119	8
9	Remodel 8 Rooms	2001	11,757	784	15	784		849	9
10	Fencing	2001	877	88	10	88		110	10
11	Generator	2002	18,497	842	20	848	6	842	11
12	Wall Panel	2002	1,829	168	10	168		168	12
13	Activity Room Flooring	2002	4,308	323	10	323		323	13
14	Concrete work	2002	937	31	20	31		31	14
15	Parking Lot Light	2002	788	31	15	31		31	15
16	Room Remodel	2002	9,522	106	15	106		106	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	TOTAL (lines 1 thru 33)		\$ 3,464,020	\$ 98,285		\$ 98,039	\$ (246)	\$ 1,475,514	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 652,320	\$ 68,231	\$ 68,231	\$		\$ 348,257	71
72	Current Year Purchases	57,273	3,459	3,459		10	3,459	72
73	Fully Depreciated Assets	260,231				5-15	259,683	73
74								74
75	TOTALS	\$ 969,824	\$ 71,690	\$ 71,690	\$		\$ 611,399	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportaion	1980 Ford Van	1990	\$ 45,725	\$	\$	\$	5	\$ 45,725	76
77	Patient Transportaion	Bus	1999	37,900	7,580	7,580		5	23,372	77
78	Patient Transportaion	Chevy Van	2002	7,500	508	508		5	508	78
79										79
80	TOTALS			\$ 91,125	\$ 8,088	\$ 8,088	\$		\$ 69,605	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)	\$	4,547,862	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	178,063	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	177,817	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(246)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,156,518	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	Cottage #1	\$ 75,325	\$ 2,404	\$ 50,681	86
87	Medical Clinic	176,944	5,684	120,582	87
88	Land Trust	49,865			88
89	Beauty & Barber	1,234		1,234	89
90	See Attached List	428,869	12,745	124,700	90
91	TOTALS	\$ 732,237	\$ 20,833	\$ 297,197	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.

**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?  YES  NO  
 If NO, see instructions.

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

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>      </u> /2003	\$ <u>      </u>
13.	<u>      </u> /2004	\$ <u>      </u>
14.	<u>      </u> /2005	\$ <u>      </u>

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized  
 by the length of the lease \_\_\_\_\_.

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

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 1,079 Description: O2 Concentrators & Nebulizers  
 (Attach a schedule detailing the breakdown of movable equipment)

\* 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.

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>99</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>56</u></p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$ 1,402	\$	\$ 1,402
2 Books and Supplies		314		314
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$ 1,716	\$	\$ 1,716
10 SUM OF line 9, col. 1 and 2 (e)	\$	1,716		

- (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 aide 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 aides.

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number North Adams Home

# 0020925

Report Period Beginning: 11/01/01

Ending:

10/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/02

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (153,853)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	354,854		3
4	Supply Inventory (priced at FIFO )	34,433		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,981		6
7	Other Prepaid Expenses	2,388		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 248,803	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	242,921		12
13	Land	72,758		13
14	Buildings, at Historical Cost	4,108,223		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,070,044		16
17	Accumulated Depreciation (book methods)	(2,424,635)		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): <u>Loan Origination Fees</u>	24,996		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,094,307	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,343,110	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 98,794	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	504,195		29
30	Accrued Salaries Payable	172,284		30
31	Accrued Taxes Payable (excluding real estate taxes)	357		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,824		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Liabilities</u>	3,731		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 781,185	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	216,701		39
40	Mortgage Payable	1,348,409		40
41	Bonds Payable			41
42	Deferred Compensation	190,123		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,755,233	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,536,418	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 806,692	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,343,110	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,239,433	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,239,433	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(412,569)	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) Cottages (Net Income)	(15,225)	15
16	Other (describe) Medical Clinic (Net Income)	(4,947)	16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (432,741)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 806,692	24 *

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number North Adams Home

# 0020925

Report Period Beginning: 11/01/01

Ending:

Page 19

10/31/02

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,244,309	1
2	Discounts and Allowances for all Levels	(15,294)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,229,015	3
<b>B. Ancillary Revenue</b>			
4	Day Care	250	4
5	Other Care for Outpatients		5
6	Therapy	9,747	6
7	Oxygen	1,711	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 11,708	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,244	12
13	Barber and Beauty Care	21,449	13
14	Non-Patient Meals	4,749	14
15	Telephone, Television and Radio	216	15
16	Rental of Facility Space		16
17	Sale of Drugs	91,490	17
18	Sale of Supplies to Non-Patients	2,331	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	463	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 126,942	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	37,483	24
25	Interest and Other Investment Income***	19,158	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 56,641	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Transportation Income</b>	15,066	28
28a	<b>See List Attached</b>	10,611	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 25,677	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,449,983	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	863,368	31
32	Health Care	1,697,589	32
33	General Administration	790,667	33
<b>B. Capital Expense</b>			
34	Ownership	316,676	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	132,810	35
36	Provider Participation Fee	61,442	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,862,552	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(412,569)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (412,569)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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: **11/01/01**

Ending: **10/31/02**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,035	2,088	\$ 47,435	\$ 22.72	1
2	Assistant Director of Nursing	1,914	2,067	42,506	20.56	2
3	Registered Nurses	5,089	5,480	93,422	17.05	3
4	Licensed Practical Nurses	34,871	36,453	493,746	13.54	4
5	Nurse Aides & Orderlies	69,946	72,735	676,394	9.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,568	6,706	73,045	10.89	8
9	Activity Director	1,953	2,088	23,825	11.41	9
10	Activity Assistants	7,851	8,208	56,640	6.90	10
11	Social Service Workers	3,559	3,751	38,276	10.20	11
12	Dietician					12
13	Food Service Supervisor	735	1,189	12,633	10.62	13
14	Head Cook	1,806	1,921	19,286	10.04	14
15	Cook Helpers/Assistants	12,932	13,400	89,311	6.67	15
16	Dishwashers	12,412	12,711	83,217	6.55	16
17	Maintenance Workers	6,099	6,460	64,080	9.92	17
18	Housekeepers	8,994	9,519	72,930	7.66	18
19	Laundry	10,467	11,171	105,107	9.41	19
20	Administrator	1,776	2,098	48,410	23.07	20
21	Assistant Administrator	2,049	2,065	33,249	16.10	21
22	Other Administrative	609	609	14,181	23.29	22
23	Office Manager					23
24	Clerical	6,800	7,179	71,408	9.95	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	1,901	1,980	19,857	10.03	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	966	966	8,814	9.12	33
34	TOTAL (lines 1 - 33)	201,332	210,844	\$ 2,187,772 *	\$ 10.38	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	188	\$ 6,820	1-3	35
36	Medical Director	Various	9,600	9-3	36
37	Medical Records Consultant	12	1,110	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	6,820	1-3	39
40	Physical Therapy Consultant	99	6,376	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	1,074	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	160	6,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	557	\$ 38,200		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9	\$ 252	10-3	50
51	Licensed Practical Nurses	401	15,305	10-3	51
52	Nurse Aides	8	143	10-3	52
53	TOTAL (lines 50 - 52)	418	\$ 15,700		53





XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See List Attached
- (3) Did the nursing home make political contributions or payments to a political 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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,228 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 of Public Aid during this cost report period. \$ 61,442  
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? Yes 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 of Public Aid, 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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,749
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 6,869  
c. What percent of all travel expense relates to transportation of nurses and patients? 86  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? 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? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

North Adams Home Board of Directors as of 10/31/02

<u>Name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>
Beeler, Russell	320 N Hwy 96	Sutter	IL	62373
Burke, Carroll	1573 Hwy 61	Loraine	IL	62349
Butler, Gary	2948 East 1000th St	Mendon	IL	62351
Finlay, Mike	RR #1 box 129 C	Mendon	IL	62351
Frese, Lawrence H.	2149 E 1200th St	Mendon	IL	62351
Hemming, Dean	PO Box 33	Ursa	IL	62376
Hibbert, Ron	PO Box 206	Mendon	IL	62351
Husemann, Ronald	1617 N 1600th Ave	Fowler	IL	62338
Tom Kamprath	309 Adams	Coatsburg	IL	62325
King, Sherri	RR #1 Box 42 A	Mendon	IL	62351
Kircher, Kathleen J.	605 S State Rd.	Mendon	IL	62351
McCleary, Judy	1276 N 2250th Ave	Mendon	IL	62351
Spohr, Edith	7211 N 96th St	Fowler	IL	62338
Ann Wesbecker	100 Birch St.	Ursa	IL	62376

\* Ron Huseman provides some woodworking and carpentry work.

\* Kathy Kircher provides pamphlets.

North Adams Home, Inc. 0020925  
 110101 thru 10/31/02  
 Line 24, Schedule XVII Sec. E

Endowment funds	\$19,904.82
Donated cash	\$598.83
Memberships	\$3,450.00
Future Development Fund	\$0.00
Hospitality Room Fund	\$711.00
Mini fair income	\$8,078.79
Van fund donations	\$1,004.75
Religious income	\$3,737.50
	<u>\$37,485.69</u>

Line 28a, Schedule XVII Sec. E

Gain on sale of Asset	\$410.00
Discounts	\$42.45
Rebates	\$1,744.40
Admission income	\$3,757.00
Activities income	\$29.45
Misc. income	\$1,659.38
Personal Purchases Income	\$1,080.87
Cookbook Revenue	\$1,280.00
Badge Replacement Income	\$10.00
	<u>\$10,610.55</u>

Schedule XIX, Sec F

IL Act Assoc. Dues	\$45.00
NAEIR Dues	\$575.00
IL Nursing Home Administrators Assoc	\$75.00
Employers Association	\$495.00
Social Service Prof. Of IL	\$59.00
Chamber Of Commerce	\$160.00
Secretary Of State	\$93.00
HCPA Lab Program	\$150.00
Canon Financial (Admin. Fees)	\$50.00
State of IL Fees	\$180.00
A New Day Magazine	\$65.90
Nurse Assn/VP Magazine	\$25.00
Mayo Health Letter	\$27.00
Quincy Herald Whig	\$1,674.40
	<u>\$2,875.30</u>

Sch. XX Question #2

a. Life Services Network	\$5,049.00
b. IL Nursing Home Admin. Assoc.	\$75.00
c. IL Activity Assoc. Dues	\$30.00
d. Social Services Prof. Of IL	\$59.00
e. NAEIR Dues	\$575.00
	<u>\$5,788.00</u>

Line 25, Schedule V

Repairs & Maint. Mini Bus	\$19.34
Repairs & Maint. Bus	\$70.44
Repairs & Maint. Chevy Van	\$397.62
Gas & Oil Mini Bus	\$214.60
Gas & Oil Bus	\$50.09
Gas & Oil Chevy Van	\$42.62
Mini Bus Misc Exp	\$2.90
Bus Misc Exp.	\$4.36
Chevy Van Misc Exp.	\$4.30
Employee Business Travel	\$978.18
	<u>\$1,774.45</u>

Line 36, Schedule V

Amortization of refinancing loan fees	\$4,143.25
Misc Exp	\$44.68
Utilization Fee	\$384.00
Bank & service fees	\$3,773.08
	<u>\$8,345.01</u>

Line 6, Schedule V

Repairs & maint. Dietary	\$4,548.82
Repairs & maint. Laundry	\$1,108.78
Repairs & maint. Bldgs	\$19,835.27
Repairs & maint. Equip.	\$17,253.02
Repairs & maint. Grounds	\$4,691.74
Repairs & maint. Office	\$2,860.27
Repairs & maint. Computers	\$6,029.24
Repairs & maint. Bldgs for Life Safety Code	\$4,506.96
Outside services	\$7,503.44
	<u>\$68,107.54</u>

Line 7, Schedule V

Waste Removal	\$9,423.00
Medical Waste Removal	\$1,011.06
	<u>\$10,434.06</u>

Line 43, Schedule V

Bad Debts	\$0.00
Sales Tax	\$432.00
	<u>\$432.00</u>

Line 27, Schedule V

Contributions	\$425.00
	<u>\$425.00</u>

Line 19, Schedule V

Hubert Staff of \$1,389.00 and North Adams State Bank of \$1,544.00  
 These are loan origination fees for Line of credit necessary due to late state payments and decrease in the modified rate.

North Adams Bank	Title Insurance	\$450.00
Union Bank	Loan Fees	\$1,023.00
North Adams Bank	Loan Fees	\$21.00
Hubert Staff	Title Insurance	\$863.75
Hubert Staff	Legal pertaining to loan	\$375.00
Hubert Staff	Legal pertaining to loan	\$160.00
		<u>\$2,892.75</u>

North Adams Home, Inc. 0020925

11/01/01 thru 10/31/02

Line 90, Schedule XI Sec. F

	Cost	Current Book	Accumulated
Cottage Sewer	\$839.00	\$21.00	\$150.00
Cottage Sewer	\$24,101.00	\$604.00	\$4,877.00
Cottage Equip	\$5,450.00	\$363.00	\$3,240.00
Land Imp.	\$6,860.00	\$0.00	\$0.00
Land Imp.	\$6,455.00	\$0.00	\$0.00
Chapel Equip	\$11,023.00	\$95.00	\$10,216.00
Cottages	\$82,066.00	\$2,672.00	\$35,413.00
Parking Lot	\$10,300.00	\$0.00	\$10,300.00
Cottage	\$127,973.00	\$4,290.00	\$42,174.00
Alarm System	\$1,650.00	\$110.00	\$1,073.00
Appliances	\$1,159.00	\$0.00	\$1,159.00
Carpet	\$1,320.00	\$88.00	\$748.00
Carpet	\$2,110.00	\$142.00	\$884.00
Carpet	\$1,070.00	\$73.00	\$465.00
Carpet	\$1,145.00	\$77.00	\$479.00
Shelves	\$500.00	\$0.00	\$491.00
Range	\$660.00	\$123.00	\$649.00
Refrigerator	\$654.00	\$131.00	\$469.00
Cottage	\$137,600.00	\$3,433.00	\$10,585.00
Carpet	\$1,388.00	\$93.00	\$285.00
Beauty Shop Remodel	\$846.00	\$106.00	\$317.00
Beauty Shop Equip	\$249.00	\$36.00	\$101.00
Refroof Cottage	\$2,486.00	\$166.00	\$442.00
Refrigerator	\$965.00	\$122.00	\$183.00
	<u>\$428,869.00</u>	<u>\$12,745.00</u>	<u>\$124,700.00</u>

North Adams Home, Inc. 0020925  
11/01/01 thru 10/31/02  
Schedule V, Reclassifications

From		To	
Line 35	(\$384)	Line 4	\$384

Reclassification due to linens being mis coded to Utilitizaion Fees

Line 19	(\$202)	Line 6	\$202
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Reclassification due to Computer repairs being miscoded to professional fees

Line 20	(\$15)	Line 24	\$15
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Reclassification due to petty cash for seminar expense ticket being miscoded to dues

Line 19	(\$50)	Line 36	\$50
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Reclassification due to bank fee being miscoded to Professional fees

Account	Debit	Credit	Total
1000 Cash		1000	1000
1010 Accounts Receivable	1000		1000
1020 Inventory	1000		1000
1030 Prepaid Insurance	1000		1000
1040 Equipment	1000		1000
1050 Accumulated Depreciation		1000	1000
2000 Accounts Payable		1000	1000
2010 Notes Payable		1000	1000
3000 Common Stock		1000	1000
3010 Retained Earnings		1000	1000
4000 Sales		1000	1000
4010 Cost of Sales	1000		1000
5000 Selling Expenses	1000		1000
5010 Administrative Expenses	1000		1000
5020 Depreciation Expense	1000		1000
5030 Interest Expense	1000		1000
5040 Income Tax Expense	1000		1000
6000 Dividends	1000		1000
7000 Net Income		1000	1000
<b>Total</b>	<b>10000</b>	<b>10000</b>	<b>10000</b>



North Adams Home, Inc. 0020925  
11/01/01 thru 10/31/02  
Schedule V, Sec. C, Line 23

In-Service

Staples	Training Materials	\$34.89
Stoney Creek	Material/Room for training	\$191.60
Master Card	Admin. Review Course	\$175.94
Sam Goody	Training Materials	\$69.50
John Wood Comm College	2 Courses for Administrator	\$265.00
Master Card	Geriatric Cert. Program	\$575.93
Master Card	Training Materials	\$447.00
CCI Audio	CCI Adio tapes	\$405.00
Hospital Compensation Service	Salary & Benefit Report	\$195.00
Accumed	Software Training	\$550.00
Safety Bingo	Bingo Cards	\$54.00
Elder Care Comm.	Preventing abuse manual	\$169.95
Quincy Fire Extinguishers	Fire Extinguisher training	\$250.00
Safety Bingo	Bingo Cards	\$144.00
Greg Sandidge	Testing	\$75.00
Computer Land	Computer Course	\$125.00
Computer Land	PowerPoint Training	\$250.00
John Wood Comm College	Real Estate Course	\$245.00
Greg Sandidge	Training Materials	\$50.33
Computer Land	Excel Training	\$125.00
John Wood Comm College	Non-credit course	\$5.00
Mea Smith	Training Materials	\$26.36
Michael Smith	Training Materials	\$8.00
Computer Land	Charting training	\$150.00
Computer Land	Excel Training	\$100.00
Computer Land	PowerPoint Training	\$800.00
Greg Sandidge	Geriatric Cert. Program	\$35.00
Greg Sandidge	Geriatric Cert. Program	\$35.00
Greg Sandidge	Admin. Review Course	\$185.32
Greg Sandidge	Admin. Review Course/Testing	\$558.38
Greg Sandidge	Admin. Testing	\$395.43
		<u>\$6,696.63</u>