

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0020925

Facility Name: North Adams Home

Address: 2259 E 1100th Street Mendon 62351
 Number City Zip Code

County: Adams

Telephone Number: 217-936-2137 **Fax #** 217-936-3106

HFS ID Number: 37-0978651001

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Greg Sandidge **Telephone Number:** 217-936-2137

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/2005 to 10/31/2006 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) <u>Greg Sandidge</u>	
	(Title) <u>Administrator</u>	
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: 11/01/2005 Ending: 10/31/2006

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 10/24/2006

	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	<u>109</u>	Skilled (SNF)	<u>99</u>	<u>39,715</u>	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	<u>109</u>	TOTALS	<u>99</u>	<u>39,715</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,063</u>	<u>10,971</u>	<u>1,783</u>	<u>33,817</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,063</u>	<u>10,971</u>	<u>1,783</u>	<u>33,817</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.15%

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)

Adult DaycareF. 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 10/16/1977

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 11 and days of care provided 1,783Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 10/31/06 Fiscal Year: 10/31/06

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

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/2005 Ending: 10/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	266,226	11,678	7,562	285,466		285,466		285,466			1
2	Food Purchase		192,486		192,486		192,486		192,486			2
3	Housekeeping	71,585	22,645	367	94,597		94,597		94,597			3
4	Laundry	67,401	13,038	31,499	111,938		111,938		111,938			4
5	Heat and Other Utilities			117,127	117,127		117,127		117,127			5
6	Maintenance	48,327	10,667	60,625	119,619		119,619		119,619			6
7	Other (specify):* Waste			9,131	9,131		9,131		9,131			7
8	TOTAL General Services	453,539	250,514	226,311	930,364		930,364		930,364			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,395,058	93,713	3,150	1,491,921		1,491,921		1,491,921			10
10a	Therapy	89,326	7,995	185,245	282,566		282,566		282,566			10a
11	Activities	62,075	4,088	2,103	68,266		68,266		68,266			11
12	Social Services	57,729			57,729		57,729		57,729			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,604,188	105,796	200,098	1,910,082		1,910,082		1,910,082			16
	C. General Administration											
17	Administrative	51,000			51,000		51,000		51,000			17
18	Directors Fees											18
19	Professional Services			67,650	67,650		67,650		67,650			19
20	Dues, Fees, Subscriptions & Promotions			40,502	40,502		40,502	(30,925)	9,577			20
21	Clerical & General Office Expenses	105,077	43,867	16,459	165,403		165,403		165,403			21
22	Employee Benefits & Payroll Taxes			276,005	276,005		276,005		276,005			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,242	7,242		7,242		7,242			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,582	79,582		79,582		79,582			26
27	Other (specify):*											27
28	TOTAL General Administration	156,077	43,867	487,440	687,384		687,384	(30,925)	656,459			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,213,804	400,177	913,849	3,527,830		3,527,830	(30,925)	3,496,905			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: 11/01/2005 Ending: 10/31/2006

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
	D. Ownership										
30	Depreciation			172,181	172,181		172,181		172,181		30
31	Amortization of Pre-Op. & Org.			4,016	4,016		4,016		4,016		31
32	Interest			133,444	133,444		133,444		133,444		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			309,641	309,641		309,641		309,641		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation	13,289		15,078	28,367		28,367		28,367		38
39	Ancillary Service Centers		34,135		34,135		34,135		34,135		39
40	Barber and Beauty Shops	17,208	565		17,773		17,773		17,773		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,572	59,572		59,572		59,572		42
43	Other (specify):* finance charges			26,018	26,018		26,018		26,018		43
44	TOTAL Special Cost Centers	30,497	34,700	100,668	165,865		165,865		165,865		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,244,301	434,877	1,324,158	4,003,336		4,003,336	(30,925)	3,972,411		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: 11/01/2005

Ending: 10/31/2006

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	5,626			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	1,885	32-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	8,565	32-7		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	1,037	32-7		28
29	Other-Attach Schedule	165	32-7		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 17,278		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 17,278		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

North Adams Home

ID# 20925
 Report Period Beginning: 11/1/2005
 Ending: 10/31/2006

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	Chamber of Commerce Dues	165	32	2
3	Yellow Page Advertising	1,037	32	3
4	Promotions Advertising			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	1,202		49

STATE OF ILLINOIS

Facility Name & ID Number North Adams Home# 0020925

Report Period Beginning:

11/01/2005 Ending:

Summary B

10/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	1,202	0	0	0	0	0	0	0	0	0	0	1,202	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	1,202	0	0	0	0	0	0	0	0	0	0	1,202	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)	1,202	0	0	0	0	0	0	0	0	0	0	1,202	45

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning: 11/01/2005 Ending: 10/31/2006

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
NA						

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	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:

11/01/2005

Ending:

10/31/2006

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	N/A								\$	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: 11/01/2005

Ending: 0/31/2006

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/2005 Ending: 10/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2	First Bankers Trust		X	Mortgage #1	\$8,030.00	10/23/01	2,000,000	1,046,882	2/23/2025	0.0644	69,868	2						
3	First Bankers Trust		X	Mortgage #2	\$3,372.00	02/24/03	530,000	461,287	05/15/2007	0.0850	35,583	3						
4	North Adams State Bank		X	Cash Flow Pay Off	\$3,248.55	03/16/01	250,000	135,275	2/23/2008	0.0750	10,621	4						
5												5						
	Working Capital																	
6	North Adams State Bank		X	Line of Credit Cash Flow	variable	04/08/04	100,000	90,000	5/1/2008	0.0800	17,372	6						
7	Northern Healthcare		X	Accounts Receivable Finance	variable	12/01/04		60,719	1/1/2007	n/a		7						
8												8						
9	TOTAL Facility Related					\$14,650.55	\$	2,880,000	\$	1,794,163	\$	133,444	9					
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$		\$		\$		14					
15	TOTALS (line 9+line14)						\$	2,880,000	\$	1,794,163	\$	133,444	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Adams Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT Greg Sandidge

TELEPHONE 2179362137 FAX #: 217 936-3106

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x 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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

11/01/2005 Ending:

10/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,950 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

North Adams Home Inc. Medical Clinic 2567 SQ FT

North Adams Home Inc. Cottages 2756 SQ FT

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Patient Care</u>	<u>435,600</u>	<u>1975</u>	<u>\$ 72,757</u>	1
2					2
3	TOTALS	435,600		\$ 72,757	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1977	1977	\$ 1,036,037	\$ 25,944	40	\$ 25,944		\$ 750,639	4
5	1		1978	1978	2,633		10			2,633	5
6	10		1986	1986	438,224	14,673	30	14,673		296,386	6
7	10		1997	1997	1,374,932	34,442	40	34,442		328,941	7
8											8
	Improvement Type**										
9											9
10				2006							10
11	None										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

*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:

11/01/2005 Ending: 10/31/2006

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	Garbage Disposal	2005	\$ 965	\$ 64	15	\$ 64	\$	\$ 128	37
38	Drapes	2005	699	93	5	93		240	38
39	PTAC Heating/AC Unit	2005	965	27	15	27		54	39
40	Matress Pressure System	2005	2,000	200	10	200		200	40
41	SCU Flooring	2005	6,840	513	15	513		1,026	41
42									42
43	Front Office Locks	2004	608	61	10	61		157	43
44	Resident Room Glass (5)	2004	735	74	10	74		166	44
45	PTAC Heating/AC Unit	2004	1,097	73	15	73		158	45
46	PTAC Heating/AC Unit	2004	965	64	15	64		128	46
47									47
48	PTAC Heating/AC Unit	2004	1,097	110	15	110		302	48
49									49
50	PTAC Heating/AC Unit	2004	1,097	110	15	110		302	50
51									51
52	PTAC Heating/AC Unit	2004	1,097	73	10	73		207	52
53	PTAC Heating/AC Unit	2004	1,097	73	10	73		201	53
54	PTAC Heating/AC Unit	2004	1,097	110	10	110		293	54
55	Hot Water Heater Elements	2004	818	82	10	82		212	55
56	Compactor Conversion Electrical Wiring	2004	750	75	10	75		194	56
57	Water Softner Elements & Resin	2004	2,438	244	10	244		650	57
58									58
59									59
60	Parking Lots Improvements	2004	3,869	774	5	774		1,999	60
61	Plumbing Replacement Drain Pipe	2004	1,000	40	25	40		100	61
62	Air Curtain	2004	578	39	15	39		96	62
63	PTAC Heating/AC Unit	2004	965	96	10	96		233	63
64	Front Office Locks	2004	613	61	10	61		163	64
65									65
66	PTAC Heating/AC Unit	2003	1,097	110	10	110		329	66
67	PTAC Heating/AC Unit	2003	965	96	10	96		281	67
68									68
69	Compactor Electrical Wiring and Service	2003	949	95	10	95		269	69
70	TOTAL (lines 4 thru 69)		\$ 2,886,227	\$ 78,416		\$ 78,416	\$	\$ 1,386,687	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:

11/01/2005 Ending: 10/31/2006

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		\$ 2,886,227	\$ 78,416		\$ 78,416	\$	\$ 1,386,687	1
2	Generator	2002	18,497	925	20	925		4,542	2
3	Wall Panel	2002	1,829	185	10	185		908	3
4	Activity Room Flooring	2002	4,308	431	10	431		2,047	4
5	Concrete Work	2002	937	47	20	47		219	5
6	Parking Lot Light	2002	788	53	15	53		241	6
7	Room Remodel	2002	9,522	635	15	635		2,645	7
8									8
9	Roof Recoating	2001	28,450	1,897	15	1,897		10,117	9
10	Carpet Special Care Unit	2001	1,780	178	10	178		941	10
11	Concrete Work	2001	1,900	95	20	95		500	11
12	Remodel 8 Rooms	2001	11,757	784	15	784		3,985	12
13	Fencing	2001	877	88	10	88		461	13
14									14
15	Power Door SCU	2000	1,233	123	10	123		1,130	15
16	New Railing	2000	670	67	10	67		435	16
17	Fire Wall	2000	21,922	1,096	20	1,096		6,850	17
18	Oxygen Room	2000	2,409	120	20	120		753	18
19	Dampers	2000	2,581	172	15	172		1,075	19
20	Duct Detectors	2000	2,285	228	10	228		1,428	20
21	Emergency Lighting	2000	2,119	212	10	212		355	21
22	Smoke Fire Dampers	2000	1,300	130	10	130		801	22
23	Emergency Lighting	2000	801	80	10	80		494	23
24									24
25	Alarm Systems	1999	2,466	164	15	164		1,232	25
26	Roof Repairs	1999	11,000	733	15	733		5,499	26
27	Landscaping	1999	992	99	10	99		710	27
28	Shower Remodel	1999	2,792	141	20	141		950	28
29									29
30	Roof Repairs Reroof	1998	5,232	349	15	349		2,950	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,024,674	\$ 87,448		\$ 87,448	\$	\$ 1,437,955	34

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

Facility Name & ID Number North Adams Home

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 12B, Carried Forward		\$ 3,024,674	\$ 87,448		\$ 87,448	\$	\$ 1,437,955	1
2	Laundry Remodel	1997	13,967	936	15	936		8,503	2
3	New Addition-Egress	1997	4,431	625	10	625		4,637	3
4	New Addition-Landscaping SCU Garden	1997	25,624	2,562	10	2,562		24,962	4
5									5
6	Patient Sensor System	1996	2,340	236	10	236		2,495	6
7	Landscaping	1996	776	77	10	77		792	7
8	Carpeting	1996	1,183	79	15	79		812	8
9	Ventilation	1996	1,154	77	15	77		772	9
10	Nursing Cabinets	1996	9,378	625	15	625		6,279	10
11									11
12	Storage Room	1995	1,662	111	15	111		1,274	12
13									13
14	Patio	1994	15,076		10			15,076	14
15	Electric Doors	1994	2,867	191	15	191		2,277	15
16									16
17	Land Improvements	1993	760		10			760	17
18	Roof Repairs	1991	82,210	4,128	20	4,128		63,636	18
19	Garage	1990	31,318	1,044	30	1,044		16,790	19
20	Parking Lot Paving	1990	10,500					10,500	20
21	Parking Lot Graving	1990	1,017					1,017	21
22	Roof Repairs	1990	1,372	91	15	91		1,363	22
23									23
24	Patient Sensor System	1989	3,964					3,964	24
25	Dining Room Remodel	1989	3,943		15			3,943	25
26									26
27	Wall Carpet	1988	12,374		15			12,374	27
28	Cabinet Doors	1988	5,316	266	20	266		4,851	28
29	Sprinklers	1988	663	27	25	27		485	29
30	Exhaust Fan Door Locks	1988	2,151		15			2,151	30
31	Sidewalk Shelter Floor	1988	2,583					2,583	31
32	Land Improvements	1988	3,052					3,052	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,264,355	\$ 98,523		\$ 98,523	\$	\$ 1,633,303	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:

11/01/2005 Ending:

10/31/2006

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 12C, Carried Forward	\$ 3,264,355	\$ 98,523		\$ 98,523	\$	\$ 1,633,303		1
2									2
3									3
4									4
5	Capital Improvements 1981-1987	1981 233,820					233,820		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	TOTAL (lines 1 thru 33)	\$ 3,498,175	\$ 98,523		\$ 98,523	\$	\$ 1,867,123		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:

11/01/2005 Ending:

10/31/2006

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 12D, Carried Forward	\$ 3,498,175	\$ 98,523		\$ 98,523	\$	\$ 1,867,123		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	TOTAL (lines 1 thru 33)	\$ 3,498,175	\$ 98,523		\$ 98,523	\$	\$ 1,867,123		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	\$ 714,709	\$ 72,133	\$ 72,133	\$	5-15	\$ 536,371	71
72	Current Year Purchases					5-10		72
73	Fully Depreciated Assets	255,786				5-15	255,786	73
74								74
75	TOTALS	\$ 970,495	\$ 72,133	\$ 72,133	\$		\$ 792,157	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1980 Ford Bus	1990	\$ 45,725	\$	\$	\$	5	\$ 45,725	76
77	Patient Transport	1999 Ford Mini Bus	1999	37,900				5	37,900	77
78	Patient Transport	1998 Chevy Van	2002	7,500	1,525	1,525		5	6,609	78
79										79
80	TOTALS			\$ 91,125	\$ 1,525	\$ 1,525	\$		\$ 90,234	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)		\$ 4,632,552	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 172,181	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 172,181	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,749,514	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	Medical Clinic	\$ 176,944	\$ 5,684	\$ 143,317	86
87	Land Trust	49,865			87
88	Beauty Shop	1,234		1,234	88
89	Attached Listing	517,510	15,399	237,487	89
90					90
91	TOTALS	\$ 745,553	\$ 21,083	\$ 382,038	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	pg 3,Line 10 A	hrs	\$	1,614	\$ 96,857	\$	1,614	\$ 96,857	1
2	Licensed Speech and Language Development Therapist	pg 3,Line 10 A	hrs		116	6,968		116	6,968	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	pg 3,Line 10 A	hrs		1,357	81,420		1,357	81,420	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	pg 3,Line 10 A	# of prescrpts				361		#VALUE!	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	pg 3,Line 10 A					800		#VALUE!	12
13	Other (specify):									13
14	TOTAL			\$	3,087	\$ 185,245	\$ 1,161	3,087	\$ #VALUE!	14

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

Facility Name & ID Number North Adams Home# 0020925Report Period Beginning: 11/01/2005

Ending:

10/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 10/31/2006

(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	\$ (4,601)	\$	1
2	Cash-Patient Deposits	1,824		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	524,331		3
4	Supply Inventory (priced at <u>lifo</u>)	33,870		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,023		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)	\$ 563,447	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	115		12
13	Land	72,758		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	2,133,747		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	9,283		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)	\$ 2,215,903	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,779,350	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 475,272	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	90,000		29
30	Accrued Salaries Payable	46,860		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>loans</u>	231,222		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 843,354	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	516,115		39
40	Mortgage Payable	1,046,826		40
41	Bonds Payable			41
42	Deferred Compensation	98,418		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,661,359	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,504,713	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 274,637	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,779,350	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 715,637	1
2	Restatements (describe):		2
3	Auditors Adjustment	(70,143)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 645,494	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(370,857)	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)	\$ (370,857)	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)	\$ 274,637	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number North Adams Home# 0020925Report Period Beginning: 11/01/2005Ending: 10/31/2006**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,736,491	1
2	Discounts and Allowances for all Levels	(247,033)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,489,458	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,851	13
14	Non-Patient Meals	10,065	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,015	19
20	Radiology and X-Ray		20
21	Other Medical Services	20,599	21
22	Laundry	3,597	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 62,127	23
D. Non-Operating Revenue			
24	Contributions	10,564	24
25	Interest and Other Investment Income***	5,465	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,029	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicl Clinic Rent	10,800	28
28a	Cottage Income	54,065	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 64,865	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,632,479	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	930,364	31
32	Health Care	1,910,082	32
33	General Administration	687,384	33
B. Capital Expense			
34	Ownership	309,641	34
C. Ancillary Expense			
35	Special Cost Centers	106,293	35
36	Provider Participation Fee	59,572	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,003,336	40
41	Income before Income Taxes (line 30 minus line 40)**	(370,857)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (370,857)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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: 11/01/2005

Ending:

10/31/2006

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	2,080	2,080	\$ 55,515	\$ 26.69	1
2	Assistant Director of Nursing	2,154	2,288	43,101	18.84	2
3	Registered Nurses	5,638	6,025	93,953	15.59	3
4	Licensed Practical Nurses	38,632	40,278	464,728	11.54	4
5	CNAs & Orderlies	65,930	68,065	737,761	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,713	5,013	62,826	12.53	8
9	Activity Director	1,565	1,972	22,516	11.42	9
10	Activity Assistants	4,833	5,051	39,407	7.80	10
11	Social Service Workers	1,830	1,920	18,587	9.68	11
12	Dietician					12
13	Food Service Supervisor	2,397	2,602	32,435	12.47	13
14	Head Cook	9,368	9,817	77,652	7.91	14
15	Cook Helpers/Assistants	7,727	7,922	65,939	8.32	15
16	Dishwashers	9,884	10,197	90,200	8.85	16
17	Maintenance Workers	4,166	4,455	48,078	10.79	17
18	Housekeepers	8,578	8,980	71,585	7.97	18
19	Laundry	6,451	6,779	67,401	9.94	19
20	Administrator	2,080	2,080	51,000	24.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,139	8,337	82,223	9.86	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	4,000	4,179	37,050	8.87	31
32	Other Health Care(specify)	2,850	3,016	28,357	9.40	32
33	Other(specify) <u>Accountant</u>	1,440	1,440	23,490	16.31	33
34	TOTAL (lines 1 - 33)	194,455	202,496	\$ 2,213,804 *	\$ 10.93	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	Contract	\$ 7,563	1-3	35
36	Medical Director	Contract	9,600	9-3	36
37	Medical Records Consultant	24	1,350	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	196	1,006	10-3	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)	220	\$ 19,519		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	766	30,652	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	766	\$ 30,652		53

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning: 11/01/2005

Ending: 10/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Gregory A. Sandidge	Administrator		\$ 51,000	Workers' Compensation Insurance	\$ 51,720	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	2,235		
				FICA Taxes	174,408	Health Care Worker Background Check			
				Employee Health Insurance	25,928	(Indicate # of checks performed <u>38</u>)	615		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Pages	1,037		
				401K Match	10,717	Public Relations	30,981		
				Life Insurance	4,114	Contributions	1,765		
				Employee Physicals	2,557	LSN Dues	4,797		
				Other Employee Benefits	6,561	Chamber of Commerce	165		
						Less: Public Relations Expense	(30,981)		
						Non-allowable advertising	()		
						Yellow page advertising	(1,037)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 51,000	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 276,005		\$ 9,577			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							Disallow out of state travel		
							In-State Travel		
							Employee Business Travel	0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	4,352	
							Hotels	700	
C. Professional Services							Mileage Parking	1,407	
Vendor/Payee	Type		Amount				Meals	783	
Hubert G. Staff	Legal		\$ 9,145				Entertainment Expense	()	
Duanne Morris	Legal		40,985				(agree to Sch. V, line 24, col. 8)		
RSM Mcladery	Consulting		4,500				TOTAL	\$ 7,242	
Hicks Pension Servoces	Pensions		1,086						
Ausher Melvin Glasser	Medicare Cost Report		3,500						
Archinetics	Life Safety Code		934						
Bennett & Middendorf	Independent Audit		7,500						
Other									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 67,650	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

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. LSN \$ 4797
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,112 Line 10 Col 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,572
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. \$ _____ Has any meal income been offset against related costs? yes Indicate the amount. \$ 10,056
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ NO
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Bennett and Middendorf The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Audit is still in progress
- (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.

Page 2 Schedule

365 Day in the Year

109 Multiply

39785 Total Beds

70 Subtract 70 Bed Days Licensed issued Oct 23

39715 New Grand Total

North Adams Home

Line 90 Schedule	Cost
Section F	
Cottage #1	\$ 75,325.00
Cottage Engineering	\$ 13,316.00
Cottage Sewer	\$ 839.00
Cottage Sewer	\$ 24,101.00
Cottage Equipment	\$ 5,450.00
Land Imp	\$ 6,860.00
Land Imp	\$ 6,455.00
Cottage #2	\$ 82,066.00
Parking Lot	\$ 10,300.00
Cottage #2	\$ 127,973.00
Alarm System	\$ 1,650.00
Appliances	\$ 1,159.00
Carpet	\$ 1,320.00
Carpet	\$ 2,110.00
Carpet	\$ 1,070.00
Carpet	\$ 1,145.00
Shelves	\$ 500.00
Range	\$ 660.00
Refrigerator	\$ 654.00
Cottage #4	\$ 137,600.00
Carpet	\$ 1,388.00
Cottage #3	\$ 2,486.00
Refrigerator	\$ 965.00
Chapel Equip	\$ 11,023.00
Beauty Shop Remodel	\$ 846.00
Beauty Shop Equip	\$ 249.00
Total	\$ 517,510.00

North Adams Home
Board of Directors
FY 2006

Disclosure of Services

Ron Huseman	President	Wood Furniture = Custom Cabinets
Rich Mealiff	Vice President	Insurance Individual Life
Sue Woodruff	Vice President	None
Bernie Venvertloh	Treasurer	None
Ann Wesbecker	Secretary	None
Linda Cornwell		None
Linda Duncan		None
Ron Hibbert		None
Betty Pracht		None