

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0020925

Facility Name: North Adams Home

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

County: Adams

Telephone Number: 219-936-2137 **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>501c3</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: Leslie Walsh **Telephone Number:** 219-936-2137

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/2006 to 10/31/07 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>Leslie Walsh</u>	
	(Title) <u>Acting Director</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: 11/01/2006 Ending: 10/31/07

III. STATISTICAL DATA

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

	1	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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</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>99</u>	TOTALS	<u>99</u>	<u>36,135</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>17,047</u>	<u>9,328</u>	<u>2,020</u>	<u>28,395</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>17,047</u>	<u>9,328</u>	<u>2,020</u>	<u>28,395</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.58%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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 2,020

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/06 Fiscal Year: 11/30/07

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

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/2006 Ending: 10/31/07

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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	207,518	17,777	2,203	227,498		227,498		227,498			1
2	Food Purchase		159,695		159,695		159,695		159,695			2
3	Housekeeping	61,045	16,648	682	78,375		78,375		78,375			3
4	Laundry	81,195	5,117	900	87,212		87,212		87,212			4
5	Heat and Other Utilities			142,174	142,174		142,174	(20,715)	121,459			5
6	Maintenance	45,598	22,306	87,257	155,161		155,161	(21,245)	133,916			6
7	Other (specify):*											7
8	TOTAL General Services	395,356	221,543	233,216	850,115		850,115	(41,960)	808,155			8
	B. Health Care and Programs											
9	Medical Director			9,670	9,670		9,670		9,670			9
10	Nursing and Medical Records	1,307,408	70,578	5,298	1,383,284		1,383,284		1,383,284			10
10a	Therapy	76,192	188	88,205	164,585		164,585		164,585			10a
11	Activities	59,611		7,561	67,172		67,172		67,172			11
12	Social Services	53,178			53,178		53,178		53,178			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,496,389	70,766	110,734	1,677,889		1,677,889		1,677,889			16
	C. General Administration											
17	Administrative	67,812			67,812		67,812		67,812			17
18	Directors Fees											18
19	Professional Services			61,888	61,888		61,888		61,888			19
20	Dues, Fees, Subscriptions & Promotions			21,782	21,782		21,782	(11,736)	10,046			20
21	Clerical & General Office Expenses	113,895		90,396	204,291		204,291		204,291			21
22	Employee Benefits & Payroll Taxes			242,771	242,771		242,771		242,771			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,608	12,608		12,608		12,608			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			25,282	25,282		25,282		25,282			26
27	Other (specify):* Penalties and prior yr			146,298	146,298		146,298	(82,533)	63,765			27
28	TOTAL General Administration	181,707		601,025	782,732		782,732	(94,269)	688,463			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,073,452	292,309	944,975	3,310,736		3,310,736	(136,229)	3,174,507			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:

11/01/2006

Ending:

10/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			144,253	144,253		144,253	2,124	146,377			30
31	Amortization of Pre-Op. & Org.			4,016	4,016		4,016		4,016			31
32	Interest			116,306	116,306		116,306		116,306			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			264,575	264,575		264,575	2,124	266,699			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			10,715	10,715		10,715		10,715			38
39	Ancillary Service Centers			151,241	151,241		151,241		151,241			39
40	Barber and Beauty Shops	14,583	566		15,149		15,149		15,149			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	14,583	566	216,159	231,308		231,308		231,308			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,088,035	292,875	1,425,709	3,806,619		3,806,619	(134,105)	3,672,514			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: 11/01/2006

Ending: 10/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(20,715)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(82,533)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,736)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Depreciation				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,984)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	2,124	30	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule Capital Expenditure	(21,245)	6	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,121)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (134,105)		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

North Adams Home

ID# 0020925
Report Period Beginning: 11/01/2006
Ending: 10/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/01/2006

Ending:

10/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(20,715)	0	0	0	0	0	0	0	0	0	0	(20,715)	5
6	Maintenance	(21,245)	0	0	0	0	0	0	0	0	0	0	(21,245)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(41,960)	0	0	0	0	0	0	0	0	0	0	(41,960)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,736)	0	0	0	0	0	0	0	0	0	0	(11,736)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(82,533)	0	0	0	0	0	0	0	0	0	0	(82,533)	27
28	TOTAL General Administration	(94,269)	0	0	0	0	0	0	0	0	0	0	(94,269)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(136,229)	0	0	0	0	0	0	0	0	0	0	(136,229)	29

STATE OF ILLINOIS

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/01/2006 Ending:

Summary B

10/31/07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	2,124	0	0	0	0	0	0	0	0	0	0	2,124	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,124	0	2,124	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)	(134,105)	0	(134,105)	45									

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning: 11/01/2006 Ending: 10/31/07

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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/2006 Ending: 10/31/07

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: 11/01/2006 Ending: 10/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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	First Bankers trust		x	Mortgage 1	\$8,031.00	10/01	\$ 2,000,000	\$ 1,005,029	2/2025		\$ 60,605	1								
2	First Bankers trust		x	Mortgage 2	\$4,499.00	2/03	530,000	455,872			40,190	2								
3	North Adame State bank		x	Cash Flow Payoff	\$2,701.00	3/01	250,000	110,605	2/2008		6,831	3								
4			x									4								
5												5								
Working Capital																				
6	North Adame State bank		x	Lion of Credit		4/04	100,000	100,000			8,680	6								
7	Northern healthcare		x	AR Finace		12/04		31,000				7								
8												8								
9	TOTAL Facility Related				\$15,231.00		\$ 2,880,000	\$ 1,702,506			\$ 116,306	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	\$ 1,702,506			\$ 116,306	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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 _____ 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

11/01/2006 Ending:

10/31/07

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).

Medical Clinic-2567 sq Ft

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>	\$	1
2					2
3	TOTALS	435,600		\$	3

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/01/2006 Ending:

10/31/07

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		1977	1978	2,633		10			2,633	5
6	10		1977	1986	438,224	14,673	30	14,673		296,386	6
7	10		1977	1997	1,374,932	34,442	40	34,442		328,941	7
8											8
	Improvement Type**										
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

*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:

11/01/2006 Ending:

10/31/07

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:

11/01/2006 Ending:

10/31/07

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			15	349	349	2,950	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,019,442	\$ 87,099		\$ 87,448	\$ 349	\$ 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		\$ 3,019,442	\$ 87,099		\$ 87,448	\$ 349	\$ 1,437,955	1
2	Laundry Remodel	1997	13,967	936	15	936			2
3	New Addition-Egress	1997	4,431	625	10	625			3
4	New Addition-Landscaping SCU Garden	1997	25,624	2,562	10	2,562			4
5									5
6	Patient Sensor System	1996	2,340	236	10	236			6
7	Landscaping	1996	776	77	10	77			7
8	Carpeting	1996	1,183	79	15	79			8
9	Ventilation	1996	1,154	77	15	77			9
10	Nursing Cabinets	1996	9,378	625	15	625			10
11									11
12	Storage Room	1995	1,662	111	15	111			12
13									13
14	Patio	1994	15,076		10				14
15	Electric Doors	1994	2,867	191	15	191			15
16									16
17	Land Improvements	1993	760		10				17
18	Roof Repairs	1991	82,210	4,128	20	4,128			18
19	Garage	1990	31,318	1,044	30	1,044			19
20	Parking Lot Paving	1990	10,500						20
21	Parking Lot Graving	1990	1,017						21
22	Roof Repairs	1990	1,372	91	15	91			22
23									23
24	Patient Sensor System	1989	3,964						24
25	Dining Room Remodel	1989	3,943		15				25
26									26
27	Wall Carpet	1988	12,374		15				27
28	Cabinet Doors	1988	5,316	266	20	266			28
29	Sprinklers	1988	663	27	25	27			29
30	Exhaust Fan Door Locks	1988	2,151		15				30
31	Sidewalk Shelter Floor	1988	2,583						31
32	Land Improvements	1988							32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,256,071	\$ 98,174		\$ 98,523	\$ 349	\$ 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 12C, Carried Forward	\$ 3,256,071	\$ 98,174		\$ 98,523	\$ 349	\$ 1,437,955		1
2	Capital Improvements 1981-1987	1981 233,820					233,820		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)	\$ 3,489,891	\$ 98,174		\$ 98,523	\$ 349	\$ 1,671,775		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 12D, Carried Forward		\$ 3,489,891	\$ 98,174		\$ 98,523	\$ 349	\$ 1,671,775	1
2	Key Pads & Smoke Detector Systems	2007	6,216	622	10	622		622	2
3	Wall Covering Life Safety System	2007	2,330	233	10	233		233	3
4	Tile Floor	2007	1,776	178	10	178		178	4
5	Paging Amplifier TPU60	2007	573	57	10	57		57	5
6	Vinyl Wall	2007	7,026	703	10	703		703	6
7	Base Molding	2007	2,423	242	10	242		242	7
8	Motor - Generator	2007	900	90	10	90		90	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)		\$ 3,511,136	\$ 100,298		\$ 100,647	\$ 349	\$ 1,673,899	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: 11/01/2006 Ending: 10/31/07

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	\$		\$ 608,504	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	255,786					255,786	73
74								74
75	TOTALS	\$ 970,495	\$ 72,133	\$ 72,133	\$		\$ 864,290	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	\$	\$	\$		\$ 45,725	76
77	Patient Transport	1999 Ford Mini Bus	1999	37,900					37,900	77
78	Patient Transport	1998 ChevY Van	2002	7,500	891	891			7,500	78
79										79
80	TOTALS			\$ 91,125	\$ 891	\$ 891	\$		\$ 91,125	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)	\$	4,572,756	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	173,322	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	173,671	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	349	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,629,314	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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? _____

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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?</p> <p><input 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	39-3	hrs	\$		\$ 67,774	\$		\$ 67,774	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,816			2,816	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			88,205			88,205	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 158,795	\$		\$ 158,795	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: 11/01/2006

Ending:

10/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 10/31/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 84,345	\$	1
2	Cash-Patient Deposits	1,135		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	594,558		3
4	Supply Inventory (priced at)	33,374		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,040		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)	\$ 716,452	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	72,758		13
14	Buildings, at Historical Cost	4,149,790		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	540,360		16
17	Accumulated Depreciation (book methods)	(2,702,437)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	5,876		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)	\$ 2,066,347	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,782,799	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 543,900	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	452,499		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 996,399	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,743,029		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,743,029	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,739,428	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 43,471	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,782,899	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(232,247)	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)	\$ (232,247)	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)	\$ (232,247)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number North Adams Home# 0020925Report Period Beginning: 11/01/2006Ending: 10/31/07**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	\$ 3,702,987	1
2	Discounts and Allowances for all Levels	(381,032)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,321,955	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	20,022	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 20,022	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	41,423	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	152,595	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 194,018	23
D. Non-Operating Revenue			
24	Contributions	38,377	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,377	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,574,372	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	850,115	31
32	Health Care	1,677,889	32
33	General Administration	782,732	33
B. Capital Expense			
34	Ownership	264,575	34
C. Ancillary Expense			
35	Special Cost Centers	177,105	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,806,619	40
41	Income before Income Taxes (line 30 minus line 40)**	(232,247)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (232,247)	43

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

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

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

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

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/01/2006

Ending:

10/31/07

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	1,960	2,080	\$ 52,499	\$ 25.24	1
2	Assistant Director of Nursing	2,050	2,258	47,668	21.11	2
3	Registered Nurses	8,721	9,202	123,052	13.37	3
4	Licensed Practical Nurses	34,269	36,217	422,964	11.68	4
5	CNAs & Orderlies	50,334	54,393	577,513	10.62	5
6	CNA Trainees	9,661	10,332	83,711	8.10	6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	3,370	3,612	76,192	21.10	8
9	Activity Director	7,990	8,461	59,611	7.05	9
10	Activity Assistants					10
11	Social Service Workers	3,541	3,821	53,178	13.92	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	3,980	4,168	35,207	8.45	13
14	Head Cook	3,706	3,904	33,996	8.71	14
15	Cook Helpers/Assistants	11,998	12,726	106,909	8.40	15
16	Dishwashers	4,188	4,379	31,406	7.17	16
17	Maintenance Workers	3,281	3,509	45,598	12.99	17
18	Housekeepers	8,527	9,074	61,045	6.73	18
19	Laundry	5,244	5,509	81,195	14.74	19
20	Administrator	1,960	2,080	67,812	32.60	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	9,671	10,436	113,895	10.91	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beauty Shop</u>			14,583		33
34	TOTAL (lines 1 - 33)	174,451	186,160	\$ 2,088,035 *	\$ 11.22	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

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 \$ 5,328
- (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. \$ 15,534 Line 10
- (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? _____
If YES, give effective date of lease. no
- (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. \$ 54,203
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? _____ Indicate the amount. \$ _____
- (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. \$ n/a
- 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? 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? _____
Firm Name: Arnold Behrens Deters and Gray 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 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.