

		FOR BHF USE					

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**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.

<p><b>I. IDPH License ID Number:</b> <u>0019091</u></p> <p><b>Facility Name:</b> <u>NORTHWEST HOME FOR THE AGED</u></p> <p><b>Address:</b> <u>6300 NORTH CALIFORNIA AVENUE CHICAGO 60659</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 773 ) 973-1900</u> <b>Fax #</b> <u>( 773 ) 973-1904</u></p> <p><b>HFS ID Number:</b> <u>36-2216170</u></p> <p><b>Date of Initial License for Current Owners:</b> _____</p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>SEYMOUR ABRAMS</u>            (Title) <u>CHAIRMAN OF THE BOARD</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>            (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u>            (Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>            (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>SEYMOUR ABRAMS</u> (Title) <u>CHAIRMAN OF THE BOARD</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>SEYMOUR ABRAMS</u> (Title) <u>CHAIRMAN OF THE BOARD</u>							
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>							

Facility Name & ID Number NORTHWEST HOME FOR THE AGED

# 0019091 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	164	Skilled (SNF)	164	59,860	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	164	TOTALS	164	59,860	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	8,390	2,900	2,871	14,161	8
9	SNF/PED					9
10	ICF	18,065	3,261		21,326	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,455	6,161	2,871	35,487	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.28%

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

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

NONE

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

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

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 2/1/73

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 164 and days of care provided 3,940

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED** # **0019091** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

**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
	<b>A. General Services</b>										
1	Dietary	371,162	52,220	8,003	431,385		431,385		431,385		1
2	Food Purchase		272,934		272,934	(55,772)	217,162	(13,943)	203,219		2
3	Housekeeping	284,838	48,705		333,543		333,543		333,543		3
4	Laundry	80,235	17,906		98,141		98,141		98,141		4
5	Heat and Other Utilities			243,594	243,594		243,594		243,594		5
6	Maintenance	43,992	40,707	63,543	148,242		148,242		148,242		6
7	Other (specify):* <b>door guards (maint)</b>	31,120		38,745	69,865		69,865		69,865		7
8	<b>TOTAL General Services</b>	811,347	432,472	353,885	1,597,704	(55,772)	1,541,932	(13,943)	1,527,989		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,500	4,500		4,500		4,500		9
10	Nursing and Medical Records	3,027,452	171,168	23,943	3,222,563		3,222,563		3,222,563		10
10a	Therapy	59,094		11,111	70,205		70,205		70,205		10a
11	Activities	182,217	23,732	660	206,609		206,609		206,609		11
12	Social Services	152,010		179	152,189		152,189		152,189		12
13	CNA Training										13
14	Program Transportation			383	383		383		383		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,420,773	194,900	40,776	3,656,449		3,656,449		3,656,449		16
	<b>C. General Administration</b>										
17	Administrative	87,868			87,868		87,868		87,868		17
18	Directors Fees										18
19	Professional Services			102,592	102,592		102,592	(1,000)	101,592		19
20	Dues, Fees, Subscriptions & Promotions			56,813	56,813		56,813	(38,836)	17,977		20
21	Clerical & General Office Expenses	190,822	19,074	32,862	242,758		242,758	(547)	242,211		21
22	Employee Benefits & Payroll Taxes			927,227	927,227	55,772	982,999		982,999		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,598	3,598		3,598	(1,003)	2,595		24
25	Other Admin. Staff Transportation			1,932	1,932		1,932		1,932		25
26	Insurance-Prop.Liab.Malpractice			170,219	170,219		170,219		170,219		26
27	Other (specify):*			107,113	107,113		107,113	(107,113)			27
28	<b>TOTAL General Administration</b>	278,690	19,074	1,402,356	1,700,120	55,772	1,755,892	(148,499)	1,607,393		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,510,810	646,446	1,797,017	6,954,273		6,954,273	(162,442)	6,791,831		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,003
	REPAIRS & MAINTENANCE	0
		0
		8,003
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	114,340
	ELECTRICITY	117,002
	WATER	4,000
	CABLE TV - LOBBY	8,252
		0
		243,594
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	1,106
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	42,649
	ELEVATOR MAINTENANCE & REPAIR	13,969
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,721
	FIRE SERVICE	1,098
		0
		0
		0
		0
		63,543
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	38,745
	SECURITY SERVICE	0
		0
		0
		38,745
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,500
		4,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	13,743
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,880
	PHARMACY CONSULTANT XVIII B 39-2	5,560
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	2,760
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		23,943
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,597
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,514
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		11,111
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	660
		0
		660
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	179
	SOCIAL WORKER XVIII B 45-2	0
		0
		179
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	383
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	17,223
	ADMINISTRATIVE CONSULTANTS XIX C	30,000
	PROFESSIONAL FEES XIX C	55,369
		0
		102,592
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	38,836
	EMPLOYEE WANT ADS XIX F	661
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	12,771
	LICENSES & PERMITS XIX F	4,535
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	10
	PATIENT BACKGROUND CHECKS XIX F	0
		56,813
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	547
	EQUIPMENT REPAIR & MAINTENANCE	8,877
	OUTSIDE CLERICAL SERVICES	12,440
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,998
	MESSENGER SERVICE	0
		0
		32,862

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	336,622
	UNEMPLOYMENT COMPENSATION XIX D	18,369
	WORKERS COMPENSATION INSURANC XIX D	126,786
	HOSPITALIZATION INSURANCE XIX D	357,289
	EMPLOYEE BENEFITS - OTHER XIX D	18,092
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	70,069
	CHICAGO HEAD TAX XIX D	0
		0
		927,227
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	3,598
	TRAVEL XIX G	0
		3,598
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,932
		1,932
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	170,219
		170,219
27	<b>OTHER</b>	
	BAD DEBTS VI 24	107,113
		107,113

GRAND TOTAL COLUMN 3 OTHER

1,797,017

**NORTHWEST HOME FOR THE AGED  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	272,934
LESS SALES TAX	<u>0</u>
NET FOOD	272,934

**HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??**

TOTAL PATIENT CENSUS	35,487
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	106,461

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	106,461
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	106,461

NET FOOD	272,934
DIVIDE TOTAL MEALS/YEAR	<u>106,461</u>

COST PER MEAL	2.56
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

=====

Facility Name & ID Number NORTHWEST HOME FOR THE AGED

#0019091

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	
	<b>D. Ownership</b>											
30	Depreciation			201,201	201,201		201,201	(8,854)	192,347			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,205	18,205		18,205	(6,147)	12,058			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			72,000	72,000		72,000	(72,000)				34
35	Rent-Equipment & Vehicles			11,492	11,492		11,492		11,492			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			302,898	302,898		302,898	(87,001)	215,897			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,626	124,696	268,322		268,322		268,322			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			89,790	89,790		89,790		89,790			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		143,626	214,486	358,112		358,112		358,112			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,510,810	790,072	2,314,401	7,615,283		7,615,283	(249,443)	7,365,840			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 **NORTHWEST HOME FOR THE AGED**

# **0019091**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,943)	2		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	(8,854)	30		9
10	Interest and Other Investment Income	(1,252)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(4,895)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(107,113)	27		24
25	Fund Raising, Advertising and Promotional	(38,836)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(74,550)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (249,443)		\$	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (249,443)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0019091

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGES	(547)	21	2
3	AMALGAMATED BANK OF CHICAGO	(1,000)	19	3
4	NON ALLOW EDUCTION & SEMINARS	(1,003)	24	4
5	RENT	(72,000)	34	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	<b>Total</b>	(74,550)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWEST HOME FOR THE AGED# 0019091

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,943)	0	0	0	0	0	0	0	0	0	0	(13,943)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(13,943)</b>	<b>0</b>	<b>(13,943)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,000)	0	0	0	0	0	0	0	0	0	0	(1,000)	19
20	Fees, Subscriptions & Promotions	(38,836)	0	0	0	0	0	0	0	0	0	0	(38,836)	20
21	Clerical & General Office Expenses	(547)	0	0	0	0	0	0	0	0	0	0	(547)	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	(1,003)	0	0	0	0	0	0	0	0	0	0	(1,003)	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):*	(107,113)	0	0	0	0	0	0	0	0	0	0	(107,113)	27
28	<b>TOTAL General Administration</b>	<b>(148,499)</b>	<b>0</b>	<b>(148,499)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(162,442)</b>	<b>0</b>	<b>(162,442)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWEST HOME FOR THE AGED# 0019091

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(8,854)	0	0	0	0	0	0	0	0	0	0	(8,854)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,147)	0	0	0	0	0	0	0	0	0	0	(6,147)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(72,000)	0	0	0	0	0	0	0	0	0	0	(72,000)	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	<b>TOTAL Ownership</b>	<b>(87,001)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(87,001)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(249,443)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(249,443)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED** # **0019091** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

**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								<b>TOTAL</b>	\$		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 NORTHWEST HOME FOR THE AGED

# 0019091

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

NORTHWEST HOME FOR THE AGED

# 0019091

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$				\$	1					
2													2					
3													3					
4													4					
5													5					
	<b>Working Capital</b>																	
6	<b>RELATED PARTY</b>	<b>X</b>		<b>WORKING CAPITAL</b>	<b>INT ONLY</b>	<b>11/2007</b>	<b>117,076</b>	<b>240,000</b>	<b>DEMAND</b>	<b>PRIME</b>		<b>13,310</b>	6					
7													7					
8													8					
9	<b>TOTAL Facility Related</b>						\$ <b>117,076</b>	\$ <b>240,000</b>				\$ <b>13,310</b>	9					
	<b>B. Non-Facility Related*</b>																	
10	<b>MISC.</b>		<b>X</b>	<b>LATE FEES</b>								<b>4,895</b>	10					
11													11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$ <b>4,895</b>	14					
15	<b>TOTALS (line 9+line14)</b>						\$ <b>117,076</b>	\$ <b>240,000</b>				\$ <b>18,205</b>	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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.

\$ \_\_\_\_\_ **1**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ \_\_\_\_\_ **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ \_\_\_\_\_ **3**

4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ \_\_\_\_\_ **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$ \_\_\_\_\_ **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND \$ \_\_\_\_\_ For \_\_\_\_\_ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**

\$ \_\_\_\_\_ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ \_\_\_\_\_ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	_____	<b>8</b>
	2003	_____	<b>9</b>
	2004	_____	<b>10</b>
	2005	_____	<b>11</b>
	2006	_____	<b>12</b>

<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$ _____ <b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$ _____ <b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$ _____ <b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$ _____ <b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

**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 NORTHWEST HOME FOR THE AGED COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0019091

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**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. _____	<u>NURSING HOME</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 50,536 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories \_\_\_\_\_

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).

N/A

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>PATIENT CARE</u>	<u>24,221</u>	<u>1993</u>	<u>\$ 162,933</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>24,221</b>		<b>\$ 162,933</b>	<b>3</b>

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	1973	1973	\$ 797,821	\$ 19,945		\$ 19,945	\$	\$ 695,517	4
5	8	1986	1986	418,000	10,450		10,450		224,675	5
6	6	1994	1994	682,486	17,052		17,052		230,202	6
7										7
8										8
	<b>Improvement Type**</b>									
9	LAND IMPROVEMENT		1973	12,360					12,360	9
10	LAND IMPROVEMENT		1981	88,292					88,292	10
11	LAND IMPROVEMENT		1982	32,553					32,553	11
12	LAND IMPROVEMENT		1983	55,207					55,207	12
13	LAND IMPROVEMENT		1984	60,325					60,325	13
14	LAND IMPROVEMENT		1985	12,481					12,481	14
15	LAND IMPROVEMENT		1986	33,262					33,262	15
16	LAND IMPROVEMENT		1986	99,906					99,906	16
17	LAND IMPROVEMENT		1987	3,507					3,507	17
18	LAND IMPROVEMENT		1988	46,957					46,957	18
19	LAND IMPROVEMENT		1989	11,021					11,021	19
20	LAND IMPROVEMENT		1989	52,943					52,943	20
21	LAND IMPROVEMENT		1993	1,500					1,500	21
22	BUILDING IMPROVEMENT		1973	314,578					314,578	22
23	BUILDING IMPROVEMENT		1974	7,564					7,564	23
24	BUILDING IMPROVEMENT		1975	24,726					24,726	24
25	BUILDING IMPROVEMENT		1976	61,018					61,018	25
26	BUILDING IMPROVEMENT		1977	16,352					16,352	26
27	BUILDING IMPROVEMENT		1978	3,161					3,161	27
28	BUILDING IMPROVEMENT		1979	77,150					77,150	28
29	BUILDING IMPROVEMENT		1980	36,176					36,176	29
30	BUILDING IMPROVEMENT		1981	24,284					24,284	30
31	BUILDING IMPROVEMENT		1982	11,976					11,976	31
32	BUILDING IMPROVEMENT		1983	51,666					51,666	32
33	BUILDING IMPROVEMENT		1984	62,215					62,215	33
34	BUILDING IMPROVEMENT		1985	16,770					16,770	34
35	BUILDING IMPROVEMENT		1986	37,684	946	20	946		38,630	35
36	BUILDING IMPROVEMENT		1987	82,905	4,145	20	4,145		84,973	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	BUILDING IMPROVEMENT	1988	\$ 47,481	\$ 2,374	20	\$ 2,374	\$	\$ 46,293	37
38	BUILDING IMPROVEMENT	1990	74,626		10			74,626	38
39	BUILDING IMPROVEMENT	1991	425		10			425	39
40	BUILDING IMPROVEMENT	1991	5,901	295	20	295		4,868	40
41	BUILDING IMPROVEMENT	1992	1,755	88	20	88		1,364	41
42	BUILDING IMPROVEMENT	1993	86,526	4,326	20	4,326		62,727	42
43	BUILDING IMPROVEMENT	1994	64,428	3,222	20	3,222		43,497	43
44	AIR INTAKE	1995	3,899	194	20	194		2,425	44
45	WATER MIXING VALUE	1995	1,474	74	20	74		925	45
46	LAVATORY FAUCETS	1995	3,662	183	20	183		2,288	46
47	HOT WATER SYSTEM	1995	10,982	549	20	549		6,863	47
48	BATH TUB SLIPRESISTENT	1995	2,700	135	20	135		1,687	48
49	GENERATOR	1995	22,900	1,145	20	1,145		14,313	49
50	NEW WALL	1996	1,405	70	20	70		805	50
51	RETURN DUCK	1996	528	26	20	26		299	51
52	H2O WATER HEATER	1996	10,711	536	20	536		6,164	52
53	H2O BOOSTER	1996	14,484	724	20	724		8,326	53
54	NEW WINDOWS	1996	763	38	20	38		437	54
55	ROOF	1996	6,000	300	20	300		3,450	55
56	SEWER SYSTEM	1996	2,350	118	20	118		1,357	56
57	NEW DECK	1996	6,100	305	20	305		3,508	57
58	SERVICE SWITCH	1996	820	41	20	41		471	58
59	ELECTRICAL	1996	2,905	145	20	145		1,668	59
60	GUTTER BOX	1996	625	31	20	31		357	60
61	ELECTRICAL WORK	1996	3,300	165	20	165		1,897	61
62	ELECTRICAL SERVICE	1996	590	30	20	30		345	62
63	ELECTRONIC MAGNETIC DOOR	1996	624	31	20	31		357	63
64	FIRE DOORS	1996	10,101	505	20	505		5,807	64
65	BOILER FLUE PIPE	1996	2,296	115	20	115		1,322	65
66	HORIZONTAL WATER COOLED A/C	1996	9,000	450	20	450		5,175	66
67	NEW PUMPS	1996	9,875	494	20	494		5,681	67
68	NEW VALVES	1996	2,368	118	20	118		1,357	68
69	ROOF	1997	35,350	1,767	20	1,767		18,554	69
70	TOTAL (lines 4 thru 69)		\$ 3,683,800	\$ 71,132		\$ 71,132	\$	\$ 2,821,585	70

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,683,800	\$ 71,132		\$ 71,132	\$	\$ 2,821,585	1
2	<b>NEW BATHROOM FLOORS</b>	1997	3,198	160	20	160		1,680	2
3	<b>MANHOLE REPAIR</b>	1998	2,350	117	20	117		1,112	3
4	<b>TILING</b>	1998	23,105	1,155	20	1,155		10,973	4
5	<b>ROOF TOP UNIT</b>	1998	6,370	319	20	319		3,030	5
6	<b>CUSOM CABINTRY</b>	1999	3,300	165	20	165		1,403	6
7	<b>CONCRETE RAMPS</b>	1999	2,000	100	20	100		850	7
8	<b>SLIDING DOOR</b>	1999	9,046	452	20	452		3,842	8
9	<b>TILING</b>	1999	6,679	334	20	334		2,839	9
10	<b>PERIMETER PLASTIC</b>	1999	2,250	112	20	112		952	10
11	<b>WINDOWS</b>	1999	4,760	238	20	238		2,023	11
12	<b>NEW MANHOLE</b>	1999	3,180	159	20	159		1,352	12
13	<b>DRAIN PIPES</b>	1999	2,800	140	20	140		1,190	13
14	<b>KICK PLATES</b>	1999	4,070	204	20	204		1,734	14
15	<b>COOLING EQUIPMENT</b>	1999	8,142	407	20	407		3,459	15
16	<b>ELECTRIC EYE</b>	1999	3,141	157	20	157		1,335	16
17	<b>WINDOWS</b>	2000	1,076	54	20	54		405	17
18	<b>SIGN</b>	2000	6,150	307	20	307		2,303	18
19	<b>FLOORING</b>	2000	7,312	366	20	366		2,745	19
20	<b>CUBICLE CURTAINS</b>	2001	10,147	507	20	507		3,296	20
21	<b>WINDOWS</b>	2001	2,060	103	20	103		669	21
22	<b>ELEVATOR REHAB</b>	2001	20,485	1,024	20	1,024		6,656	22
23	<b>DRAINS AND GREASE TRAPS</b>	2001	3,500	175	20	175		962	23
24	<b>CONDENSING UNITS AND WIRING</b>	2001	9,965	498	20	498		2,665	24
25	<b>TILING</b>	2001	82,110	4,106	20	4,106		26,689	25
26	<b>OVERBED LIGHTS AND SCONCES</b>	2001	28,520	1,426	20	1,426		9,569	26
27	<b>STEEL DOORS</b>	2001	2,640	132	20	132		858	27
28	<b>WALLCOVERINGS</b>	2001	4,168	208	20	208		1,352	28
29	<b>CORNICES WITH BLACKOUT LINED DRAPERY</b>	2001	18,276	914	20	914		5,941	29
30	<b>FLOORING</b>	2001	31,589	1,580	20	1,580		10,270	30
31	<b>PAINTING</b>	2001	48,425	2,421	20	2,421		15,737	31
32	<b>CORNICES</b>	2001	8,833	442	20	442		2,873	32
33	<b>CRASHBARS, WALL BORDERS &amp; CORNERGUARDS</b>	2001	29,120	1,456	20	1,456		9,464	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,082,567	\$ 91,070		\$ 91,070	\$	\$ 2,961,813	34

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,082,567	\$ 91,070		\$ 91,070	\$	\$ 2,961,813	1
2	<u>CORNICES, CORNER GUARDS &amp; CUBICLE TRACKS</u>	2001	15,202	760	20	760		4,940	2
3	<u>BUILT-IN WARDROBES</u>	2001	54,924	2,746	20	2,746		17,849	3
4	<u>TILING, WALLPAPER &amp; PAINTING 4 BATHROOMS</u>	2001	11,741	587	20	587		3,816	4
5	<u>SCONCES</u>	2001	1,179	59	20	59		384	5
6	<u>CORNER GUARDS</u>	2001	345	17	20	17		111	6
7	<u>AMBULANCE DOOR</u>	2001	420	21	20	21		136	7
8	<u>WALLCOVERING</u>	2001	2,288	115	20	115		747	8
9	<u>CUSTOM ORDER SCREEN SPRINT</u>	2001	9,825	491	20	491		3,191	9
10	<u>CARPETING</u>	2001	8,810	441	20	441		2,866	10
11	<u>VINYL FLOORING IN ACTIVITY ROOM</u>	2001	5,287	264	20	264		1,716	11
12	<u>CROWN MOLDING &amp; HANDRAILS</u>	2001	7,266	363	20	363		2,360	12
13	<u>CRASH RAILS &amp; BED LOCATORS</u>	2001	9,322	466	20	466		3,029	13
14	<u>CRASH RAILS</u>	2001	3,346	167	20	167		1,086	14
15	<u>CORNER GUARDS</u>	2001	563	28	20	28		182	15
16	<u>CEILING</u>	2001	13,271	664	20	664		4,333	16
17	<u>SCONCES</u>	2001	1,915	191	10	191		1,146	17
18	<u>PAINTING</u>	2001	5,214	521	10	521		3,126	18
19	<u>CUBICLE CURTAINS</u>	2001	788	79	10	79		474	19
20	<u>CARPETING &amp; COVE BASE</u>	2001	10,000	1,000	10	1,000		6,000	20
21	<u>LAND IMPROVEMENT-CONCRETE WORK</u>	2002	4,100	410	10	410		2,255	21
22	<u>BLINDS</u>	2002	658	66	10	66		363	22
23	<u>CORNICE &amp; DRAPES</u>	2002	4,721	472	10	472		2,596	23
24	<u>DOORS</u>	2002	12,752	638	20	638		3,509	24
25	<u>CEILING TILE</u>	2002	1,926	96	20	96		528	25
26	<u>FIRE CODE WORK</u>	2002	80,256	4,013	20	4,013		22,072	26
27	<u>FLOORING</u>	2002	4,721	236	20	236		1,298	27
28	<u>WALLS</u>	2002	8,824	441	20	441		2,426	28
29	<u>CEILING SYSTEM</u>	2002	8,507	425	20	425		2,338	29
30	<u>RECESSED DOWNLIGHTS</u>	2002	602	30	20	30		165	30
31	<u>WIRING</u>	2002	6,195	310	20	310		1,704	31
32	<u>EXIT DOOR ALRM CONTROL PANEL</u>	2002	1,130	57	20	57		313	32
33	<u>PLASTERING, PAINTING</u>	2003	1,800	90	20	90		405	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,380,465	\$ 107,334		\$ 107,334	\$	\$ 3,059,277	34

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,380,465	\$ 107,334		\$ 107,334	\$	\$ 3,059,277	1
2	TILING	2003	2,495	125	20	125		562	2
3	WALLCOVERING	2003	9,951	497	20	497		2,237	3
4	WINDOW	2003	962	48	20	48		216	4
5	PA SPEAKER SYSTEM	2003	630	31	20	31		140	5
6	CABLE WIRE & ATLET BOXES	2003	3,215	161	20	161		724	6
7	EXIT SIGN	2003	1,230	62	20	62		279	7
8	CEILING DIFFUSES	2003	2,417	121	20	121		544	8
9	BLINDS	2004	1,000	100	10	100		350	9
10	CARPET,WALLPAPER	2004	3,897	390	10	390		1,365	10
11	WALLCOVERING	2004	4,122	412	10	412		1,442	11
12	DOORS	2004	63,245	3,162	20	3,162		11,067	12
13	DOOR MAGNET HOLDERS	2004	9,985	499	20	499		1,747	13
14	SMOKE DETECT	2004	6,713	336	20	336		1,176	14
15	PUSH BUTTON LOCKS FOR DOORS	2004	1,070	54	20	54		189	15
16	ROOF REPAIR	2004	5,541	277	20	277		969	16
17	REMODEL BATHROOMS	2005	4,186	209	20	209		522	17
18	MASONRY WORK	2005	92,504	4,625	20	4,625		11,563	18
19	WOOD HANDRAILS	2005	5,280	264	20	264		660	19
20	SENTRY ELEVATOR	2005	67,000	3,350	20	3,350		8,375	20
21	BUILT IN CABINETS	2005	4,409	220	20	220		550	21
22	FIRE DAMPERS	2005	2,103	105	20	105		262	22
23	EXIT DOOR ALARM SYSTEM	2005	1,070	54	20	54		135	23
24	ELECTRIC DOOR HOLDER	2005	827	41	20	41		103	24
25	ELECTRICAL WORK	2005	2,870	144	20	144		360	25
26	WINDOW TREATMENTS & WALL SCONCES	2005	12,544	1,254	10	1,254		3,135	26
27	WALLPAPER	2005	6,600	660	10	660		1,650	27
28	ACCORDION FOLDING PARTITIONS	2005	5,970	597	10	597		1,493	28
29	CAMERA MONITORING SYSTEM	2005	8,075	808	10	808		2,020	29
30	COMPRESSOR	2005	2,460	246	10	246		615	30
31	HEAT PUMP	2005	7,225	722	10	722		1,805	31
32	FLOORING	2005	28,677	2,868	10	2,868		7,170	32
33	WALL MOUNTED A/C	2005	3,006	301	10	301		752	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,751,744	\$ 130,077		\$ 130,077	\$	\$ 3,123,454	34

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

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 4,751,744	\$ 130,077		\$ 130,077	\$	\$ 3,123,454	1
2	PHOTOELECTRIC SMOKE DETECTORS	2006	2,087	104	20	104		156	2
3	ELECTRICAL	2006	4,745	237	20	237		355	3
4	FIRE PANEL	2006	24,448	1,222	20	1,222		1,833	4
5	ELEVATOR REHAB	2006	18,401	920	20	920		1,380	5
6	HOT WATER HEATER	2006	7,670	384	20	384		576	6
7	SEWAGE PUMP	2006	7,824	391	20	391		587	7
8	FIRE ALARM PANEL	2006	8,502	425	20	425		638	8
9	EXIT DOOR ALARM	2006	1,355	68	20	68		102	9
10	CEILING TILE IN KITCHEN	2006	11,750	588	20	588		882	10
11	2 HOT WATER BOILERS WITH NEW BOILERS	2007	66,402	1,660	20	1,660		1,660	11
12	FIRE ALARM	2007	26,878	672	20	672		672	12
13	DUCTLESS 2.5 TON SPLIT SYSTE M	2007	3,800	95	20	95		95	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,935,606	\$ 136,843		\$ 136,843	\$	\$ 3,132,390	34

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**

# **0019091**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**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	\$ 1,825,379	\$ 63,157	\$ 54,750	\$ (8,407)		\$ 319,303	71
72	Current Year Purchases	15,087	1,201	754	(447)		754	72
73	Fully Depreciated Assets	1,298,705					1,298,705	73
74								74
75	<b>TOTALS</b>	\$ 3,139,171	\$ 64,358	\$ 55,504	\$ (8,854)		\$ 1,618,762	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		1998 CHRYSLER T & C	1997	\$ 26,467	\$	\$	\$		\$ 26,467	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 26,467	\$	\$	\$		\$ 26,467	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)	\$ 8,264,177	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 201,201	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 192,347	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,854)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,777,619	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	<b>TOTALS</b>	\$	\$	\$	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:	164		\$ 72,000			3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	164		\$ 72,000			7

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

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

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

**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: \$ 7,342 Description: **SEE SCHEDULE ATTACHED**

(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	ADMINISTRATOR	TOYOTA CAMRY	\$ 375.00	\$ 4,150	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 375.00	\$ 4,150	21

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 \$ \_\_\_\_\_

\* 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>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 17,101	\$		\$ 17,101	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,996			10,996	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			90,072			90,072	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				119,539		119,539	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): med. Supply,lab,rental					6,527	24,087		30,614	13
14	<b>TOTAL</b>			\$		\$ 124,696	\$ 143,626		\$ 268,322	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 **NORTHWEST HOME FOR THE AGED**

# **0019091**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2007**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 158,376	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>629,943</u> )	2,979,122		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	255,268		6
7	Other Prepaid Expenses	4,606		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,397,372	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	162,933		13
14	Buildings, at Historical Cost	1,898,307		14
15	Leasehold Improvements, at Historical Cost	3,037,299		15
16	Equipment, at Historical Cost	1,900,928		16
17	Accumulated Depreciation (book methods)	(4,799,685)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>rent security deposit</u>	139,011		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,338,793	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,736,165	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,053,868	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,078		28
29	Short-Term Notes Payable	390,000		29
30	Accrued Salaries Payable	733,942		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,683		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>interfund transfer</u>	11,009,737		36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 13,231,308	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 13,231,308	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (7,495,143)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,736,165	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(4,710,372)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>post closing entries</b>	<b>(311,463)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(5,021,835)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(2,473,308)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(2,473,308)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(7,495,143)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,943,923	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,943,923	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	108,152	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 108,152	8
	<b>C. Other Operating Revenue</b>		
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	(769)	13
14	Non-Patient Meals		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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ (769)	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	89,417	24
25	Interest and Other Investment Income***	1,252	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 90,669	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,141,975	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,597,704	31
32	Health Care	3,656,449	32
33	General Administration	1,700,120	33
	<b>B. Capital Expense</b>		
34	Ownership	302,898	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	268,322	35
36	Provider Participation Fee	89,790	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,615,283	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,473,308)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,473,308)	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.  
FORM 990 HASN'T BEEN COMPLETED AS OF COST REPORT FILING DATE

\*\*\* 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 **NORTHWEST HOME FOR THE AGED**

# **0019091**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

**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	2,121	2,215	\$ 96,613	\$ 43.62	1
2	Assistant Director of Nursing	1,406	1,757	62,303	35.46	2
3	Registered Nurses	34,639	39,685	1,176,076	29.64	3
4	Licensed Practical Nurses	10,494	12,095	301,214	24.90	4
5	CNAs & Orderlies	86,911	96,847	1,205,126	12.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,691	4,174	59,094	14.16	8
9	Activity Director	2,251	2,422	56,497	23.33	9
10	Activity Assistants	6,505	7,570	125,720	16.61	10
11	Social Service Workers	5,871	6,690	152,010	22.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	215	570	9,930	17.42	14
15	Cook Helpers/Assistants	28,674	31,219	361,232	11.57	15
16	Dishwashers					16
17	Maintenance Workers	5,912	6,237	75,112	12.04	17
18	Housekeepers	22,850	25,409	284,838	11.21	18
19	Laundry	5,836	6,588	80,235	12.18	19
20	Administrator	1,271	1,500	86,220	57.48	20
21	Assistant Administrator	86	86	1,648	19.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,826	8,596	190,822	22.20	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	5,349	5,973	77,100	12.91	31
32	Other Health C: <b>NURSES ADMIN.</b>	3,681	4,230	109,020	25.77	32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>235,589</b>	<b>263,863</b>	<b>\$ 4,510,810 *</b>	<b>\$ 17.10</b>	<b>34</b>

\* 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	M	\$ 8,003	1-3	35
36	Medical Director	O	4,500	9-3	36
37	Medical Records Consultant	N	1,880	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,560	10-3	39
40	Physical Therapy Consultant	L	5,597	10a-3	40
41	Occupational Therapy Consultant	Y	5,514	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	660	11-3	44
45	Social Service Consultant	E	179	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>		<b>\$ 31,893</b>		<b>49</b>

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	63	2,307	10-3	51
52	Certified Nurse Assistants/Aides	510	11,436	10-3	52
53	<b>TOTAL (lines 50 - 52)</b>	<b>573</b>	<b>\$ 13,743</b>		<b>53</b>





Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL ASSOC. OF HEALTH CARE \$3936
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,599 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 89,790  
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. \$ 55,772 Has any meal income been offset against related costs? N/A 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? NO 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? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
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.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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