

Facility Name & ID Number North Adams Home

0020925 Report Period Beginning: ##### Ending:

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	99	Skilled (SNF)		36,135	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	99	TOTALS		36,135	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					
		2 Medicaid Recipient		3 Private Pay	4 Other		5 Total
		8	SNF	15,642	9,290		2,602
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	15,642	9,290	2,602	27,534	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.20%

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 69 and days of care provided 2,602

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/07 Fiscal Year: 11/30/08

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

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/2007 Ending: 10/31/2008

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	200,452	20,677	1,095	222,224		222,224		222,224		1
2	Food Purchase		186,046		186,046		186,046		186,046		2
3	Housekeeping	56,937	13,805	1,195	71,937		71,937		71,937		3
4	Laundry	80,731	7,818		88,549		88,549		88,549		4
5	Heat and Other Utilities			136,999	136,999		136,999	(10,664)	126,335		5
6	Maintenance	51,876	8,714	67,257	127,847		127,847	(1,270)	126,577		6
7	Other (specify):*										7
8	TOTAL General Services	389,996	237,060	206,546	833,602		833,602	(11,934)	821,668		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,243,977	79,096	12,512	1,335,585		1,335,585		1,335,585		10
10a	Therapy	53,954	2,145	279,814	335,913		335,913		335,913		10a
11	Activities	51,407		7,847	59,254		59,254		59,254		11
12	Social Services	30,780			30,780		30,780		30,780		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,380,118	81,241	310,973	1,772,332		1,772,332		1,772,332		16
	C. General Administration										
17	Administrative	15,961			15,961		15,961		15,961		17
18	Directors Fees										18
19	Professional Services			242,283	242,283		242,283		242,283		19
20	Dues, Fees, Subscriptions & Promotions			17,502	17,502		17,502	(13,376)	4,126		20
21	Clerical & General Office Expenses	117,360		69,711	187,071		187,071	(4,850)	182,221		21
22	Employee Benefits & Payroll Taxes			263,132	263,132		263,132		263,132		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,469	5,469		5,469		5,469		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,826	64,826		64,826		64,826		26
27	Other (specify):*										27
28	TOTAL General Administration	133,321		662,923	796,244		796,244	(18,226)	778,018		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,903,435	318,301	1,180,442	3,402,178		3,402,178	(30,160)	3,372,018		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:

11/01/2007

Ending:

10/31/2008

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			144,000	144,000		144,000		144,000			30
31	Amortization of Pre-Op. & Org.							(13,376)	(13,376)			31
32	Interest			114,714	114,714		114,714		114,714			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			258,714	258,714		258,714	(13,376)	245,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			116,115	116,115		116,115		116,115			39
40	Barber and Beauty Shops	15,271	520		15,791		15,791		15,791			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,500	54,500		54,500		54,500			42
43	Other (specify):*			9,924	9,924		9,924		9,924			43
44	TOTAL Special Cost Centers	15,271	520	180,539	196,330		196,330		196,330			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,918,706	318,821	1,619,695	3,857,222		3,857,222	(43,536)	3,813,686			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: 11/01/2007

Ending: 10/31/2008

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	(11,934)	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	(13,376)	31		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(8,090)	37		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(4,850)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,250)		\$	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			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (38,250)		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						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: 11/01/2007

Ending: 10/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Cottage refund	\$ (4,850)	21	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	(4,850)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/01/2007

Ending:

10/31/2008

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	(11,934)	0	0	0	0	0	0	0	0	0	0	(11,934)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(11,934)	0	0	0	0	0	0	0	0	0	0	(11,934)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(4,850)	0	0	0	0	0	0	0	0	0	0	(4,850)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,850)	0	0	0	0	0	0	0	0	0	0	(4,850)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,784)	0	0	0	0	0	0	0	0	0	0	(16,784)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Adams Home# 0020925

Report Period Beginning:

11/01/2007 Ending:10/31/2008

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	(13,376)	0	0	0	0	0	0	0	0	0	0	(13,376) 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	(13,376)	0	0	0	0	0	0	0	0	0	0	(13,376) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(30,160)	0	0	0	0	0	0	0	0	0	0	(30,160) 45

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning: 11/01/2007 Ending: 10/31/2008

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	Total		\$			\$	\$ *	14

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

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/2007 Ending: 10/31/2008

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: 11/01/2007 Ending: #####

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/2007 Ending: 10/31/2008

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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	\$ 980,723	2/2005		\$ 69,186	1
2	First Bankers Trust		x	Mortgage 2	\$4,499.00	2/03	530,000	450,012			44,436	2
3	North Adams State Bank		x	Cash Flow	\$2,701.00	3/01	250,000	90,479	2/2008		581	3
4												4
5												5
	Working Capital											
6	North Adams State Bank		x	Line of Credit		4/04	100,000	70,281			511	6
7	Northern Healthcare		x	Ar Finance		12/04		20,484				7
8												8
9	TOTAL Facility Related				\$15,231.00		\$ 2,880,000	\$ 1,611,979			\$ 114,714	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	\$ 1,611,979			\$ 114,714	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2007 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 2008 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:	<table border="1"> <tr><td>2003</td><td>8</td></tr> <tr><td>2004</td><td>9</td></tr> <tr><td>2005</td><td>10</td></tr> <tr><td>2006</td><td>11</td></tr> <tr><td>2007</td><td>12</td></tr> </table>	2003	8	2004	9	2005	10	2006	11	2007	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003	8																										
2004	9																										
2005	10																										
2006	11																										
2007	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2007 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Adams Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT Leslie Walsh

TELEPHONE 2179362137 FAX #: 279362659

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(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 Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

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:

11/01/2007 Ending:

10/31/2008

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

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

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

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

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

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

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

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

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/1/2007

Ending:

10/31/2008

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	88	1977	1977	\$ 1,036,037	\$ 25,944	40	\$ 25,944		\$ 776,583	4
5	1	1977	1978	2,633		10			2,633	5
6	10	1977	1986	438,224	14,673	30	14,673		311,059	6
7	10	1977	1997	1,374,932	34,442	40	34,442		674,442	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:

11/01/2007 Ending: 10/31/2008

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		\$ 192		37
38	Drapes	2005	699	93	5	93		333		38
39	PTAC Heating/AC Unit	2005	965	27	15	27		81		39
40	Matress Pressure System	2005	2,000	200	10	200		400		40
41	SCU Flooring	2005	6,840	513	15	513		1,539		41
42										42
43	Front Office Locks	2004	608	61	10	61		218		43
44	Resident Room Glass (5)	2004	735	74	10	74		240		44
45	PTAC Heating/AC Unit	2004	1,097	73	15	73		231		45
46	PTAC Heating/AC Unit	2004	965	64	15	64		192		46
47										47
48	PTAC Heating/AC Unit	2004	1,097	110	15	110		412		48
49										49
50	PTAC Heating/AC Unit	2004	1,097	110	15	110		412		50
51										51
52	PTAC Heating/AC Unit	2004	1,097	73	10	73		280		52
53	PTAC Heating/AC Unit	2004	1,097	73	10	73		274		53
54	PTAC Heating/AC Unit	2004	1,097	110	10	110		403		54
55	Hot Water Heater Elements	2004	818	82	10	82		294		55
56	Compactor Conversion Electrical Wiring	2004	750	75	10	75		269		56
57	Water Softner Elements & Resin	2004	2,438	244	10	244		894		57
58										58
59										59
60	Parking Lots Improvements	2004	3,869	774	5	774		2,773		60
61	Plumbing Replacement Drain Pipe	2004	1,000	40	25	40		140		61
62	Air Curtain	2004	578	39	15	39		135		62
63	PTAC Heating/AC Unit	2004	965	96	10	96		233		63
64	Front Office Locks	2004	613	61	10	61		224		64
65										65
66	PTAC Heating/AC Unit	2003	1,097	110	10	110		439		66
67	PTAC Heating/AC Unit	2003	965	96	10	96		391		67
68										68
69		2003	949	95		95		364		69
70	TOTAL (lines 4 thru 69)		\$ 2,886,227	\$ 78,416		\$ 78,416	\$	\$ 1,776,080		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:

11/01/2007 Ending: 10/31/2008

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	\$	\$ 1,776,080	1
2	Generator	2002	18,497	925	20	925		5,467	2
3	Wall Panel	2002	1,829	185	10	185		1,093	3
4	Activity Room Flooring	2002	4,308	431	10	431		2,478	4
5	Concrete Work	2002	937	47	20	47		266	5
6	Parking Lot Light	2002	788	53	15	53		294	6
7	Room Remodel	2002	9,522	635	15	635		3,280	7
8									8
9	Roof Recoating	2001	28,450	1,897	15	1,897		12,014	9
10	Carpet Special Care Unit	2001	1,780	178	10	178		1,119	10
11	Concrete Work	2001	1,900	95	20	95		595	11
12	Remodel 8 Rooms	2001	11,757	784	15	784		4,769	12
13	Fencing	2001	877	88	10	88		549	13
14									14
15	Power Door SCU	2000	1,233	123	10	123		1,253	15
16	New Railing	2000	670	67	10	67		502	16
17	Fire Wall	2000	21,922	1,096	20	1,096		7,946	17
18	Oxvgen Room	2000	2,409	120	20	120		873	18
19	Dampers	2000	2,581	172	15	172		1,247	19
20	Duct Detectors	2000	2,285	228	10	228		1,656	20
21	Emergency Lighting	2000	2,119	212	10	212		567	21
22	Smoke Fire Dampers	2000	1,300	130	10	130		931	22
23	Emergency Lighting	2000	801	80	10	80		574	23
24									24
25	Alarm Systems	1999	2,466	164	15	164		1,396	25
26	Roof Repairs	1999	11,000	733	15	733		6,232	26
27	Landscaping	1999	992	99	10	99		809	27
28	Shower Remodel	1999	2,792	141	20	141		1,091	28
29									29
30		1998		349	15	349		3,299	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,019,442	\$ 87,448		\$ 87,448	\$	\$ 1,836,380	34

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

STATE OF ILLINOIS

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/01/2007 Ending: 10/31/2008

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	\$ 87,448		\$ 87,448		\$ 1,836,380	1
2	Laundry Remodel	1997	13,967		15				2
3	New Addition-Egress	1997	4,431		10				3
4	New Addition-Landscaping SCU Garden	1997	25,624		10				4
5									5
6	Patient Sensor System	1996	2,340		10				6
7	Landscaping	1996	776		10				7
8	Carpeting	1996	1,183		15				8
9	Ventilation	1996	1,154		15				9
10	Nursing Cabinets	1996	9,378		15				10
11									11
12	Storage Room	1995	1,662		15				12
13									13
14	Patio	1994	15,076		10				14
15	Electric Doors	1994	2,867		15				15
16									16
17	Land Improvements	1993	760		10				17
18	Roof Repairs	1991	82,210		20				18
19	Garage	1990	31,318		30				19
20	Parking Lot Paving	1990	10,500						20
21	Parking Lot Graving	1990	1,017						21
22	Roof Repairs	1990	1,372		15				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		20				28
29	Sprinklers	1988	663		25				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	\$ 87,448		\$ 87,448		\$ 1,836,380	34

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

STATE OF ILLINOIS

Page 12D

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning:

11/01/2007 Ending: 10/31/2008

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	\$ 87,448		\$ 87,448		\$ 1,836,380	1
2	Garage	1981	26,358						2
3	Building Improvement	1979	1,158						3
4	Building Improvement	1983	2,105						4
5	Building Improvement	1985	1,082						5
6	Building Improvement	1977	6,339						6
7	Land Improvement	1978	3,756						7
8	Land Improvement	1979	15,608						8
9	Land Improvement	1980	1,556						9
10	Land Improvement	1982	337						10
11	Land Improvement	1983	11,703						11
12	Land Improvement	1985	2,618						12
13	Land Improvement IDPA	1986	7,661						13
14	Generator	1979	11,412						14
15	Intercom System	1980	1,319						15
16	Fixed Equipment	1982	29,082						16
17	Building Improvement	1986	28,142						17
18	Building Improvement	1986	47,328						18
19	Building Improvement	1987	9,880						19
20	Building Improvement	1987	4,145						20
21	Building Improvement	1987	6,319						21
22	Building Improvement	1987	3,244						22
23	Land Improvement IDPA	1986	10,159						23
24	Land Improvement IDPA	1987	1,192						24
25	Land Improvement	1987	1,255						25
26	Building Improvement	1981	62						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,489,891	\$ 87,448		\$ 87,448		\$ 1,836,380	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:

11/01/2007 Ending: 10/31/2008

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	\$ 87,448		\$ 87,448	\$	\$ 1,836,380	1
2	Key Pads & Smoke Detector Systems	2007	6,216		10				2
3	Wall Covering Life Safety System	2007	2,330		10				3
4	Tile Floor	2007	1,776		10				4
5	Paging Amplifier TPU60	2007	573		10				5
6	Vinyl Wall	2007	7,026		10				6
7	Base Molding	2007	2,423		10				7
8	Motor - Generator	2007	900		10				8
9									9
10	Copper Blade	2008	800		5				10
11	New Sounder System South	2008	1,095		5				11
12	New Sounder System Mid/East	2008	968		5				12
13	Wander Guard Unit	2008	1,072		5				13
14	Congleum Flooring - Chappel	2008	651		10				14
15	Congoleum Flooring - East	2008	821		10				15
16	Steam Table	2008	1,555		10				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)		\$ 3,518,097	\$ 87,448		\$ 87,448	\$	\$ 1,836,380	34

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

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	\$ 56,552	\$ 56,552	\$		\$ 665,056	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	255,786					255,786	73
74								74
75	TOTALS	\$ 970,495	\$ 56,552	\$ 56,552	\$		\$ 920,842	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	1999 Ford Mini Bus	1999	\$ 37,900	\$	\$			\$ 37,900	76
77	Patient Transport	1998 Chevy Van	2002	7,500					7,500	77
78										78
79										79
80	TOTALS			\$ 45,400	\$	\$	\$		\$ 45,400	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)	\$ 4,533,992	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 144,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,000	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,802,622	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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.

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 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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	1,175	\$	85,285	\$	2,145	1,175	\$	87,430	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		50		3,922			50		3,922	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a-3	hrs		2,699		190,607			2,699		190,607	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescripts										9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify):												13	
14	TOTAL			\$	3,924	\$	279,814	\$	2,145	3,924	\$	281,959	14	

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

STATE OF ILLINOIS

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/2007 Ending: 10/31/2008
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/2008 (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	\$ 57,677	\$	1
2	Cash-Patient Deposits	1,135		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	850,204		3
4	Supply Inventory (priced at)	33,374		4
5	Short-Term Investments			5
6	Prepaid Insurance	(6,726)		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)	\$ 935,664	\$	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	4,132,790		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	431,524		16
17	Accumulated Depreciation (book methods)	(2,719,046)		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)	\$ 1,923,902	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,859,566	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 750,793	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	427,080		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)	\$ 1,177,873	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,604,255		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	57,899		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,662,154	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,840,027	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 19,539	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,859,566	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 43,471	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 43,471	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(23,932)	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)	\$ (23,932)	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)	\$ 19,539	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning: 11/-01/07

Ending:

Page 19

10/31/2008

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	\$ 3,549,537	1
2	Discounts and Allowances for all Levels	(360,721)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,188,816	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,590	6
7	Oxygen	2,454	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 365,044	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	15,509	13
14	Non-Patient Meals	6,526	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	65,960	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	165,051	21
22	Laundry	3,330	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 256,376	23
D. Non-Operating Revenue			
24	Contributions	19,832	24
25	Interest and Other Investment Income***	3,224	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,056	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)	\$ 3,833,292	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	808,210	31
32	Health Care	1,838,788	32
33	General Administration	748,939	33
B. Capital Expense			
34	Ownership	272,760	34
C. Ancillary Expense			
35	Special Cost Centers	134,025	35
36	Provider Participation Fee	54,500	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,857,222	40
41	Income before Income Taxes (line 30 minus line 40)**	(23,930)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (23,930)	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: **11/1/2007**Ending: **10/31/2008**

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	1,930	2,080	\$ 52,660	\$ 25.32	1
2	Assistant Director of Nursing	2,078	2,249	53,191	23.65	2
3	Registered Nurses	3,966	4,087	54,075	13.23	3
4	Licensed Practical Nurses	36,059	37,652	464,939	12.35	4
5	CNAs & Orderlies	47,383	49,883	566,392	11.35	5
6	CNA Trainees	7,568	7,652	71,181	9.30	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,234	4,406	53,954	12.25	8
9	Activity Director	2,184	2,223	25,499	11.47	9
10	Activity Assistants	2,979	3,055	25,908	8.48	10
11	Social Service Workers	2,626	2,981	30,780	10.33	11
12	Dietician					12
13	Food Service Supervisor	2,439	2,503	35,016	13.99	13
14	Head Cook	4,524	4,589	37,887	8.26	14
15	Cook Helpers/Assistants	10,567	10,755	87,715	8.16	15
16	Dishwashers	5,368	5,439	39,834	7.32	16
17	Maintenance Workers	4,878	5,007	51,876	10.36	17
18	Housekeepers	5,966	6,309	56,937	9.02	18
19	Laundry	5,885	6,131	80,731	13.17	19
20	Administrator	440	440	15,962	36.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,832	8,156	98,898	12.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop					33
34	TOTAL (lines 1 - 33)	160,906	165,597	\$ 1,903,435 *	\$ 11.49	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

Facility Name & ID Number North Adams Home

0020925

Report Period Beginning: 11/1/2007

Ending: #

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
- (3) Did the nursing home make political contributions or payments to a political organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,899 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. \$ 54,500
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 benefit: on Schedule V. \$ _____ Has any meal income been offset against related costs? no 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? _____
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. \$ no
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Arnold, Behrens Deter 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. 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.