

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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>I. IDPH License ID Number: <u>0020925</u></p> <p>Facility Name: <u>NORTH ADAMS HOME</u></p> <p>Address: <u>2259 E. 1100TH STREET</u> <u>MENDON</u> <u>62351</u> Number City Zip Code</p> <p>County: <u>ADAMS</u></p> <p>Telephone Number: <u>219-936-2137</u> Fax # <u>217-936-2659</u></p> <p>HFS ID Number: <u>37-0978651001</u></p> <p>Date of Initial License for Current Owners: <u>10/16/1977</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>ROBYN JOHNSON</u> Telephone Number: <u>217-936-2137</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>11/01/08</u> to <u>10/31/09</u> and certify to the best of my knowledge and belief that the said content 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="0"> <tr> <td style="border: 1px solid black; width: 150px;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>ROBYN JOHNSON</u></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td style="border: 1px solid black;">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>ROBYN JOHNSON</u>		(Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (____) _____ Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Firm Name & Address) _____																																						
	(Telephone) (____) _____ Fax # (____) _____																																						

Facility Name & ID Number NORTH ADAMS HOME

0020925 Report Period Beginning: 11/01/08 Ending: 10/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>17,935</u>	<u>6,906</u>	<u>5,470</u>	<u>30,311</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,935</u>	<u>6,906</u>	<u>5,470</u>	<u>30,311</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.88%

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 5,470

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: 1998 Fiscal Year: 10/31/09

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

Facility Name & ID Number **NORTH ADAMS HOME** # **0020925** Report Period Beginning: **11/01/08** Ending: **10/31/09**

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	208,223	8,117	20,955	237,295		237,295		237,295		1
2	Food Purchase		179,611		179,611		179,611		179,611		2
3	Housekeeping	65,891	12,582	2,248	80,721		80,721		80,721		3
4	Laundry	81,520	11,483		93,003		93,003		93,003		4
5	Heat and Other Utilities			148,405	148,405		148,405	(13,513)	134,892		5
6	Maintenance	45,405	6,398	43,662	95,465		95,465		95,465		6
7	Other (specify):*										7
8	TOTAL General Services	401,039	218,191	215,270	834,500		834,500	(13,513)	820,987		8
	B. Health Care and Programs										
9	Medical Director	54,258			54,258		54,258		54,258		9
10	Nursing and Medical Records	1,188,002	166,279	75,415	1,429,696		1,429,696	(33,787)	1,395,909		10
10a	Therapy	46,499	1,136	323,312	370,947		370,947		370,947		10a
11	Activities	88,310	6,802		95,112		95,112		95,112		11
12	Social Services	29,698		2,065	31,763		31,763		31,763		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,406,767	174,217	400,792	1,981,776		1,981,776	(33,787)	1,947,989		16
	C. General Administration										
17	Administrative	19,135			19,135		19,135		19,135		17
18	Directors Fees										18
19	Professional Services			238,698	238,698		238,698		238,698		19
20	Dues, Fees, Subscriptions & Promotions			46,668	46,668		46,668		46,668		20
21	Clerical & General Office Expenses	164,707	36,336	243,347	444,390		444,390	(258,338)	186,052		21
22	Employee Benefits & Payroll Taxes			257,317	257,317		257,317		257,317		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,950	2,950		2,950		2,950		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			18,418	18,418		18,418		18,418		26
27	Other (specify):*										27
28	TOTAL General Administration	183,842	36,336	807,398	1,027,576		1,027,576	(258,338)	769,238		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,991,648	428,744	1,423,460	3,843,852		3,843,852	(305,638)	3,538,214		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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			136,954	136,954		136,954	(18,958)	117,996			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214,920	214,920		214,920	(75,080)	139,840			32
33	Real Estate Taxes							7,814	7,814			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							33,787	33,787			35
36	Other (specify):*											36
37	TOTAL Ownership			351,874	351,874		351,874	(52,437)	299,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							1,275	1,275			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	15,671	771		16,442		16,442		16,442			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	15,671	771		16,442		16,442	1,275	17,717			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,007,319	429,515	1,775,334	4,212,168		4,212,168	(356,800)	3,855,368			45

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

NORTH ADAMS HOME

ID# 0020925

Report Period Beginning: 11/01/08

Ending: 10/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

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

Facility Name & ID Number

NORTH ADAMS HOME

0020925

Report Period Beginning:

11/01/08

Ending:

10/31/09

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: 11/01/08 Ending: 10/31/09

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:

11/01/08

Ending: 10/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

NORTH ADAMS HOME

0020925

Report Period Beginning:

11/01/08

Ending:

10/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	FIRST BANKERS TRUST		X	IST MORTGAGE	\$8,031.00		\$ 2,000,000	\$ 941,459	03/04/2025	0.0644	\$ 73,286	1							
2	FIRST BANKERS TRUST		X	2ND MORTGAGE	\$4,203.00		530,000	434,712	03/24/2010	0.0700	25,192	2							
3	NORTH ADAMS STATE BANK		X	CASH FLOW	\$2,702.00		250,000	62,855		0.0700	5,250	3							
4												4							
5												5							
Working Capital																			
6	NORTH ADAMS STATE BANK	X		LINE OF CREDIT			100,000	100,000	08/15/2009	0.0750	7,500	6							
7	NORTH ADAMS STAE BANK		X	LINE OF CREDIT				28,135	08/26/2009	0.0750	3,461	7							
8	HIL DODGE BANK		X	LINE O CREDIT			21,847	21,847	11/10/2009	0.0600	218	8							
9	TOTAL Facility Related				\$14,936.00		\$ 2,901,847	\$ 1,589,008			\$ 114,907	9							
B. Non-Facility Related*																			
10	INTERNAL REVENUE SERVICE		X	TAX	\$2,800.00			378,060		0.0500	25,433	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related				\$2,800.00		\$	\$ 378,060			\$ 25,433	14							
15	TOTALS (line 9+line14)						\$ 2,901,847	\$ 1,967,068			\$ 140,340	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.)

Facility Name & ID Number NORTH ADAMS HOME

0020925 Report Period Beginning:

11/01/08 Ending:

10/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,950 B. General Construction Type: Exterior BRICK Frame FIRE RESISTANT Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

MEDICAL CLINIC - 2567 SQ. FT.
COTTAGES - 2756 SQ. FT.

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>PATIENT CARE</u>	<u>435,600</u>	<u>1975</u>	<u>\$ 72,758</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	435,600		\$ 72,758	3

Facility Name & ID Number NORTH ADAMS HOME

0020925

Report Period Beginning:

11/01/08

Ending:

10/31/09

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	\$ 25,901	40	\$ 25,901	\$	\$ 823,896	4
5	1			1986	438,224	14,607	30	14,607		337,577	5
6	10			1990	31,318	1,044	30	1,044		19,748	6
7				1997	1,374,932	34,373	40	34,373		438,780	7
8											8
		Improvement Type**									
9		ROOM FURNITURE		2005	11,322	942	15	942		3,850	9
10		PTAC HEATING UNIT		2005	965	64	15	64		256	10
11		FRONT OFFICE LOCKS		2004	1,221	122	10	122		915	11
12		RESIDENT ROOM GLASS (5)		2004	735	74	10	74		370	12
13		PTAC HEATING UNITS (5)		2004	8,512	710	15	710		3,245	13
14		COMPACTOR ELECTRICAL WIRING		2004	750	75	10	75		375	14
15		WATER SOFTENER ELEMENTS & RESIN		2004	2,438	244	10	244		1,220	15
16		PARKING LOT IMPROVMENTS		2004	3,869	774	5	774		3,870	16
17		PLUMBING REPLACEMENT DRAIN PIPE		2004	1,000	40	25	40		200	17
18		AIR CURTAIN		2004	578	39	15	39		195	18
19		PTAC HEATING A/C UNITS (5)		2003	2,062	207	10	207		1,242	19
20		GENERATOR		2002	18,497	925	20	925		6,475	20
21		WALL PANEL		2004	1,829	183	10	183		915	21
22		ACTIVITY ROOM FLOORING		2002	4,308	431	10	431		3,017	22
23		CONCRETE WORK		2002	937	47	20	47		329	23
24		PARKING LOT LIGHT		2002	788	53	15	53		371	24
25		ROOM REMODEL		2002	9,522	635	15	635		4,445	25
26		ROOF RECOATING		2001	28,450	1,897	15	1,897		15,176	26
27		CARPET SPECIAL CARE UNIT		2001	1,780	178	10	178		1,424	27
28		CONCRETE WORK		2001	1,900	95	20	95		760	28
29		REMODEL 8 ROOMS		2001	11,757	784	15	784		6,272	29
30		FENCING		2001	877	88	10	88		792	30
31		POWER DOOR, RAILING		2000	1,903	190	10	190		1,710	31
32		FIRE WALL		2000	21,922	1,138	20	1,138		10,242	32
33		OXYGEN ROOM AND DAMPERS		2000	4,990	250	20	250		2,628	33
34		DUCT DETECTORS		2000	2,285	229	10	229		2,061	34
35		EMERGENCY LIGHTING		2000	2,119	212	10	212		1,908	35
36		SMOKE FIRE DAMPERS		2000	1,300	130	10	130		1,170	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:

11/01/08

Ending:

10/31/09

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	EMERGENCY LIGHTING	2000	\$ 801	\$ 80	10	\$ 80	\$	\$ 720	37
38	ALARM SYSTEMS, ROOF REPAIRS	1999	17,250	1,136	15	1,136		11,360	38
39	LAUNDRY REMODEL	1997	13,967	931	15	931		11,172	39
40	CARPETING	1996	1,183	79	15	79		1,027	40
41	VENTILATION	1996	1,154	77	15	77		1,001	41
42	NURSING CABINETS	1997	9,378	625	15	625		7,500	42
43	STORAGE ROOM	1995	1,662	111	15	111		1,554	43
44	ELECRIC DOORS	1994	2,867	191	15	191		2,865	44
45	ROOF REPAIRS	1991	82,210	4,111	20	4,111		78,109	45
46	GARAGE	1990	31,318	1,044	30	1,044		19,836	46
47	PARKING LOT PAVING AND GRADING	1990	11,517	576	20	576		10,944	47
48	SIDEWALK SHELTER FLOOR	1988	3,246	130	25	130		2,759	48
49	GARAGE	1981	26,358	879	30	879		22,854	49
50	BUILDING IMPROVEMENT	1983	2,105	70	30	70		1,820	50
51	BUILDING IMPROVEMENT	1985	1,082	36	30	36		864	51
52	LAND IMPROVEMENT	1979	39,483	1,315	30	1,315		35,506	52
53	BUILDING IMPROVEMENT	1986	75,470	2,516	30	2,516		57,490	53
54	BUILDING IMPROVEMENT	1987	24,843	828	30	828		18,216	54
55	BUILDING IMPROVEMENT	1981	10,159	339	30	339		7,458	55
56	BUILDING IMPROVEMENT	1989	636,465	32,004	20	32,004		422,458	56
57	REAL ESTATE - 1617 GRANDVIEW	2009	31,403						57
58	WEST WING IOMPOVEMENT	2009	230,651		15				58
59	LESS - COTTAGES AND MEDICAL CLINIC		(634,185)	(20,094)		(20,094)		(394,263)	59
60	COPPER BLADE, SOUND SYSTEM	2008	3,935	787	5	787		787	60
61	CONGLEOM FLOORING, TABLE	2008	3,027	303	10	303		303	61
62	KEY PADS & SMOKE DETE 4 COSRSYSTEMS	2007	21,244	2,125	10	2,125		4,340	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,677,720	\$ 116,880		\$ 116,880	\$	\$ 2,022,114	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 3,750,478	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,880	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,880	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)	\$ 2,022,114	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

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	1,330	\$ 102,671	\$	1,330	\$ 102,671	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		102	8,007		102	8,007	2
3	Licensed Recreational Therapist	10A-3	hrs		4,047	212,634		4,047	212,634	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,479	\$ 323,312	\$	5,479	\$ 323,312	14

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

Facility Name & ID Number **NORTH ADAMS HOME**# **0020925**Report Period Beginning: **11/01/08**

Ending:

10/31/09**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **10/31/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 98,121	\$	1
2	Cash-Patient Deposits	1,858		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>212,187</u>)	706,744		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,018		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)	\$ 812,741	\$	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	4,032,752		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	279,154		16
17	Accumulated Depreciation (book methods)	(2,416,378)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	2,467		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)	\$ 1,970,753	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,783,494	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,008,122	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,795		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,571		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,420		32
33	Accrued Interest Payable	6,973		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	378,060		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,568,941	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	212,837		39
40	Mortgage Payable	1,376,171		40
41	Bonds Payable			41
42	Deferred Compensation	31,488		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,620,496	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,189,437	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (405,942)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,783,495	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (398,593)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (398,593)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,349)	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)	\$ (7,349)	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)	\$ (405,942)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number NORTH ADAMS HOME

0020925

Report Period Beginning: 11/01/08

Ending: 10/31/09

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	\$ 3,767,325	1
2	Discounts and Allowances for all Levels	(2,687)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,764,638	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,798	13
14	Non-Patient Meals	7,076	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	70,511	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	88	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,930	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 94,403	23
D. Non-Operating Revenue			
24	Contributions	329,834	24
25	Interest and Other Investment Income***	4,256	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 334,090	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	11,685	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,685	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,204,816	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	862,572	31
32	Health Care	2,123,596	32
33	General Administration	857,683	33
B. Capital Expense			
34	Ownership	351,874	34
C. Ancillary Expense			
35	Special Cost Centers	16,440	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,212,165	40
41	Income before Income Taxes (line 30 minus line 40)**	(7,349)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (7,349)	43

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

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

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

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

Facility Name & ID Number **NORTH ADAMS HOME**

0020925

Report Period Beginning:

11/01/08

Ending:

10/31/09

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	2,029	2,029	\$ 54,258	\$ 26.74	1
2	Assistant Director of Nursing	1,819	1,819	44,112	24.25	2
3	Registered Nurses	3,266	3,266	72,200	22.11	3
4	Licensed Practical Nurses	20,100	20,100	300,891	14.97	4
5	CNAs & Orderlies	43,423	43,423	440,748	10.15	5
6	CNA Trainees	40,673	40,673	345,722	8.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,818	3,818	46,499	12.18	8
9	Activity Director	4,102	4,102	58,994	14.38	9
10	Activity Assistants	3,250	3,250	29,317	9.02	10
11	Social Service Workers	3,058	3,058	29,698	9.71	11
12	Dietician					12
13	Food Service Supervisor	1,468	1,468	25,052	17.07	13
14	Head Cook	2,344	2,344	20,698	8.83	14
15	Cook Helpers/Assistants	5,562	5,562	44,494	8.00	15
16	Dishwashers	13,767	13,767	117,979	8.57	16
17	Maintenance Workers	3,632	3,632	45,405	12.50	17
18	Housekeepers	7,635	7,635	65,891	8.63	18
19	Laundry	8,039	8,039	81,520	10.14	19
20	Administrator	612	612	19,135	31.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,914	15,914	164,707	10.35	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) BEAUTICIAN					33
34	TOTAL (lines 1 - 33)	184,511	184,511	\$ 2,007,320 *	\$ 10.88	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
ROBYN JOHNSON	ADM	0	\$ 19,135	Workers' Compensation Insurance	\$ 69,686	IDPH License Fee	\$		
				Unemployment Compensation Insurance	12,262	Advertising: Employee Recruitment	454		
				FICA Taxes	149,205	Health Care Worker Background Check (Indicate # of checks performed)	920		
				Employee Health Insurance	12,141	Patient Background Checks	1,008		
				Employee Meals		PUBLIC RELATIONS	23,430		
				Illinois Municipal Retirement Fund (IMRF)*		SUBSCRIPTIONS	4,882		
				401G PLAN	13,653	DUES	15,974		
				EMPLOYEE PHYSICALS	5,026				
				EMPLOYEE LIFE INSURANCE	4,203				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 19,135	TOTAL (agree to Schedule V, line 22, col.8)		\$ 46,668			
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
			\$				Yellow page advertising ()		
							TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 46,668		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
ARNOLD, BEHRENS, NESBIT	ACCOUNTING		\$ 11,435			\$	Out-of-State Travel	\$	
MAIN STAFFING SOLUTIONS	TEMP. HIRING		5,713						
ACCESS STAFFING CAPITAL	TEMP. HIRING		226						
OMNI FINANCIAL	TAX		2,500				In-State Travel		
DENNIS WOODWORTH	LEGAL		3,668						
CENTERS FOR MEDICARE	LEGAL		1,925						
STAFF, BRENNER, STAFF	LEGAL		15,564						
POSINELLI SOLUTION	LEGAL		1,662				Seminar Expense	566	
WESSELS SHERMAN	LEGAL		609				TRAINING	2,384	
CORNERSTONE	CLINICAL		3,894						
REVERE HEALTHCAAE	MANAGEMENT		186,810						
OTHER	CLINICAL		5,692				Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 239,698	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,950

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NORTH ADAMS HOME

0020925

Report Period Beginning: 11/01/08

Ending: 10/31/09

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 action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,066 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? NO YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO NO 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. \$ 0
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. \$ 0 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? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: ARNOLD, BEHRENS, DETER, GRAY, NEBITT
- (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.