

		FOR BHF USE					

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**2018**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2018)**

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

<p><b>I. IDPH License ID Number:</b> <u>0020925</u></p> <p><b>Facility Name:</b> <u>NORTH ADAMS HOME, INC.</u></p> <p><b>Address:</b> <u>2259 E 1100TH ST.</u> <u>MENDON</u> <u>62351</u>  Number City Zip Code</p> <p><b>County:</b> <u>ADAMS</u></p> <p><b>Telephone Number:</b> <u>217-936-2137</u> <b>Fax #</b> <u>217-936-2659</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10-16-1977</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> <u>501c(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____ </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>DEBORAH HULL</u> <b>Telephone Number:</b> <u>217-936-2137</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501c(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>11-01-17</u> to <u>10-31-18</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>DEBORAH HULL</u> (Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <span style="float: right;">Phone # (217) 782-1630</span></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>DEBORAH HULL</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 checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501c(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>DEBORAH HULL</u> (Title) <u>ADMINISTRATOR</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number NORTH ADAMS HOME, INC.

# 0020925 Report Period Beginning: 11-01-17 Ending: 10-31-18

**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	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,828	6,678	1,311	19,817	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,828	6,678	1,311	19,817	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 59.01%

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

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONE

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

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

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 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 92 and days of care provided 1,311

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: 10-31-18 Fiscal Year: 10-31-18

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	197,299	6,210	6,755	210,264		210,264		210,264		1
2	Food Purchase		125,535		125,535		125,535		125,535		2
3	Housekeeping	48,435	10,248		58,683		58,683		58,683		3
4	Laundry	79,068	7,380		86,448		86,448		86,448		4
5	Heat and Other Utilities			112,622	112,622		112,622	(6,531)	106,091		5
6	Maintenance	65,724	3,992		69,716		69,716		69,716		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	390,526	153,365	119,377	663,268		663,268	(6,531)	656,737		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,440	11,440		11,440		11,440		9
10	Nursing and Medical Records	1,180,775	120,933	11,489	1,313,197		1,313,197		1,313,197		10
10a	Therapy			166,253	166,253		166,253		166,253		10a
11	Activities	70,021	2,079		72,100		72,100		72,100		11
12	Social Services	33,417	22		33,439		33,439		33,439		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,284,213	123,034	189,182	1,596,429		1,596,429		1,596,429		16
	<b>C. General Administration</b>										
17	Administrative	76,703			76,703		76,703		76,703		17
18	Directors Fees										18
19	Professional Services			24,604	24,604		24,604		24,604		19
20	Dues, Fees, Subscriptions & Promotions			22,648	22,648		22,648		22,648		20
21	Clerical & General Office Expenses	166,931	54,974	111,074	332,979		332,979		332,979		21
22	Employee Benefits & Payroll Taxes			359,951	359,951		359,951		359,951		22
23	Inservice Training & Education			1,017	1,017		1,017		1,017		23
24	Travel and Seminar			1,102	1,102		1,102		1,102		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,017	64,017		64,017		64,017		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	243,634	54,974	584,413	883,021		883,021		883,021		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,918,373	331,373	892,972	3,142,718		3,142,718	(6,531)	3,136,187		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, INC.

#0020925

Report Period Beginning:

11-01-17

Ending:

10-31-18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			121,367	121,367	(13,925)	107,442		107,442			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,714	100,714		100,714	(7,906)	92,808			32
33	Real Estate Taxes			5,621	5,621		5,621		5,621			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			227,702	227,702	(13,925)	213,777	(7,906)	205,871			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation	25,186		4,182	29,368	13,925	43,293		43,293			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	11,376	375		11,751		11,751		11,751			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,331	112,331		112,331		112,331			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	36,562	375	116,513	153,450	13,925	167,375		167,375			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,954,935	331,748	1,237,187	3,523,870		3,523,870	(14,437)	3,509,433			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, INC.**

# **0020925**

Report Period Beginning:

**11-01-17**

Ending:

**10-31-18**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	6,531	LINE 5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	7,906	LINE 32		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 14,437		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 14,437		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.	XX		\$ 43,293	LINE 38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops	XX		11,751	LINE 41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 55,044	47

<b>BHF USE ONLY</b>							
48		49		50		51	

NORTH ADAMS HOME, INC.

ID# 0020925

Report Period Beginning: 11-01-17

Ending: 10-31-18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning:

11-01-17

Ending:

10-31-18

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
<b>C. General Administration</b>														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	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	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning:

11-01-17

Ending:

10-31-18

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

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

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

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

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

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

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

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

Facility Name & ID Number

NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning:

11-01-17

Ending:

10-31-18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jim Totsch	BOD						1
2	Gerri Buss	BOD						2
3	Daron Duke	BOD						3
4	Ken Lubker	BOD						4
5	Lisa Seals	BOD						5
6	Paul Terwelp	BOD						6
7	Carol Anderson	BOD						7
8	Toni Hemming	BOD						8
9	Rich Martin	BOD						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

Facility Name & ID Number NORTH ADAMS HOME, INC. # 0020925 Report Period Beginning: 11-01-17 Ending: 10-31-18

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, INC.

# 0020925

Report Period Beginning:

11-01-17

Ending: 10-31-18

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning:

11-01-17

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10-31-18

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	FIRST BANKERS TRUST		NO	IST MORTGAGE	\$6,548.00	10-31-01	\$ 2,000,000	\$ 454,364	03-24-25	3.1450	\$ 15,721	1								
2	FIRST BANKERS TRUST		NO	2ND MORTGAGE	\$6,465.00	05-01-15	900,000	812,435	05-01-35	5.9500	48,685	2								
3	FIRST BANKERS TRUST		NO	LINE OF CREDIT		02-20-09	275,000	275,000	01-10-19	7.5000	17,281	3								
4	FIRST BANKERS TRUST		NO	BUS		11-10-17	55,245	55,245	01-10-19	7.5000	3,513	4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$13,013.00		\$ 3,230,245	\$ 1,597,044			\$ 85,200	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,230,245	\$ 1,597,044			\$ 85,200	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2017 report.		\$	<b>10,816</b>	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.)		\$	<b>12,328</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,512</b>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>4,109</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>5,621</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	<b>12,573</b>	8	
	2014	<b>12,751</b>	9	
	2015	<b>12,895</b>	10	
	2016	<b>12,730</b>	11	
	2017	<b>12,328</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.**

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME NORTH ADAMS HOME, INC. COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT DEBORAH HULL

TELEPHONE 217-936-2137 FAX #: 217-936-2659

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-0708-004-00</u>	<u>COMMERCIAL</u>	\$ <u>12,730.00</u>	\$ <u>12,730.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>12,730.00</u></u>	\$ <u><u>12,730.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO        NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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, INC.

# 0020925 Report Period Beginning:

11-01-17 Ending:

10-31-18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,952 B. General Construction Type: Exterior BRICK Frame 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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: LAND, 435,600, 1975, \$ 72,758, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 435,600, (blank), \$ 72,758, 3.

Facility Name & ID Number **NORTH ADAMS HOME, INC.**

# **0020925**

Report Period Beginning:

**11-01-17**

Ending:

**10-31-18**

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	81	1977	1977	\$ 761,833	\$	40	\$	\$ 761,833	\$
5	1	1986	1986						
6	10	1997	1997	1,389,482	32,120	40	32,120		829,282
7									
8									
<b>Improvement Type**</b>									
9	GARAGE	1990		31,318	1,044	30	1,044		28,100
10	PTAC HEATING	2005		965	64	15	64		768
11	PTAC HEATING AC UNITS (6)	2004		8,512	567	15	567		7,781
12	PLUMBING REPLACEMENT DRAIN PIPE	2004		1,000	40	25	40		520
13	AIR CURTAIN	2004		578	39	15	39		507
14	GENERATOR	2002		18,497	925	20	925		13,875
15	CONCRETE WORK	2002		937	47	20	47		705
16	ROOM REMODEL	2002		9,522	632	15	632	9,522	
17	CONCRETE WORK	2001		1,900	95	20	95		1,520
18	FIRE WALL	2000		21,922	1,096	20	1,096		19,094
19	OXGEN ROOM AND DAMPERS	2000		4,990	250	20	250		4,628
20	BUILDING IMPROVEMENTS	1986		75,470	368	30	368	75,470	
21	BUILDING IMPROVEMENTS	1987		24,843	831	30	831	24,843	
22	BUILDING IMPROVEMENTS	1989		2,280	114	20	114		1,192
23	BOILER	10/30/2009		32,053	1,603	20	1,603		11,221
24	FIRE PANEL	11/30/2009		31,611	1,581	20	1,581		11,067
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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, INC.**

# **0020925**

Report Period Beginning:

**11-01-17**

Ending:

**10-31-18**

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ <b>2,417,713</b>		\$ <b>41,416</b>	\$ <b>41,416</b>	\$ <b>871,668</b>	\$ <b>930,260</b>	<b>70</b>

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

Facility Name &amp; ID Number NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning:

11-01-17

Ending:

10-31-18

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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		\$ 2,417,713	\$ 41,416		\$ 41,416	\$ 871,668	\$ 930,260	1
2	WEST WING RENOVATION								2
3	LABOR	2009	87,631	5,842	15	5,842		46,736	3
4	ELECTRICAL	2009	13,837	922	15	922		7,376	4
5	CONCRETE	2009	5,350	357	15	357		2,856	5
6	BUILDING MATERIALS -								6
7	DRYWALL, LUMBER, NAILS,SCREWS	2009	60,358	4,024	15	4,024		32,192	7
8	ARCHITECT	2009	1,109	74	15	74		592	8
9	CLOTHES CLOSET	2009	1,850	123	15	123		984	9
10	CARPET	2009	15,052	1,003	15	1,003		8,024	10
11	PLUMBING	2009	8,863	591	15	591		4,728	11
12	ROOM CALL LIGHTS	2009	774	52	15	52		416	12
13	PAINT FOR ROOMS	2009	2,266	151	15	151		1,208	13
14	SPRINKLER SYSTEM	2009	21,300	1,420	15	1,420		11,360	14
15	AIR CONDITION UNITS	2006	8,563	571	15	571		4,568	15
16	SIGNS	2006	4,713	314	15	314		2,512	16
17	PLUMBING - WEST WING	2011	4,795	320	15	320		2,240	17
18									18
19	ROOF SKIN	2012	46,920	3,128	15	3,128		15,901	19
20	SPRINKLER SYSTEM	2012	41,340	2,756	15	2,756		15,388	20
21	SPRINKLER SYSTEM	2013	2,975	198	15	198		875	21
22	CARPET	2013	2,720	181	15	181		800	22
23	CARPET	2014	3,880	388	10	388		1,843	23
24	HORTON 7100 EASY ACCCESS DOOR	2015	1,994	199	10	199		647	24
25	UNDERGROUND DRAINAGE IN KITCHEN	2015	4,950	495	10	495		1,568	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,758,953	\$ 64,525		\$ 64,525	\$ 871,668	\$ 1,093,074	34

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

Facility Name &amp; ID Number NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning:

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## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,758,953	\$ 64,525		\$ 64,525	\$ 871,668	\$ 1,093,074	1
2	VINYL REPLACEMENT WINDOWS - PHYSICAL								2
3	THERAPY ROOM	2016	1,586	159	10	159		450	3
4	SHOWER ROOM -								4
5	CORNER HUARD FOR WHOWER	2016	109	11	10	11		28	5
6	CABINETS	2016	642	64	10	64		165	6
7	ELECTRICAL	2016	115	12	10	12		31	7
8	PLUMBING	2016	158	16	10	16		41	8
9	PAINT AND GLUE	2016	99	10	10	10		26	9
10	LABOR - CARPENTER	2016	6,210	621	10	621		1,604	10
11	STEEL STUDS AND LUMBER	2016	857	86	10	86		222	11
12	RESIDENT WINDOW -								12
13	LABOR - CARPENTER	2016	1,564	156	10	156		403	13
14	WINDOW	2016	1,376	138	10	138		356	14
15	WASHER DRY ROOM -								15
16	LABOR - CARPENTER	2016	2,990	299	10	299		772	16
17	DOOR	2016	488	49	10	49		126	17
18									18
19	NEW CONDUCT & CIRCUITING FOR LIFE SAFETY								19
20	FOR GENERATOR -								20
21	ELECTRICAL WIRING AND CABLE	2016	1,898	127	15	127		286	21
22	BOX ADAPTER CLIP , SCREWS CPLGNIPPLE	2016	761	51	15	51		115	22
23	AS-BUILT DRAWING	2016	225	15	15	15		34	23
24	STRIP LIGHT	2016	327	22	15	22		49	24
25	INSULTATION	2016	167	11	15	11		25	25
26	WIRE NUTS AND BOLTS	2016	138	9	15	9		20	26
27	LOT OF SQD MATERIAL	2016	1,634	109	15	109		245	27
28	WDKD #8 WALL DRILLER KIT	2016	171	11	15	11		25	28
29	D322 60A 240V RT SWITCH	2016	138	9	15	9		20	29
30	LABOR - CARPENTER	2016	26,287	1,752	15	1,752		3,944	30
31	18 GAUGE STEEL DOOR	2016	3,147	210	10	210		210	31
32	FULLY DEPRECIATED		(871,668)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,938,372	\$ 68,472		\$ 68,472	\$ 871,668	\$ 1,102,271	34

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

Facility Name & ID Number NORTH ADAMS HOME, INC.

# 0020925

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XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 235,295	\$ 23,560	\$ 23,560	\$	8-15-YRS.	\$ 152,453	71
72	Current Year Purchases	13,559	975	975		8-15 YRS.	975	72
73	Fully Depreciated Assets	(10,879)						73
74								74
75	TOTALS	\$ 237,975	\$ 24,535	\$ 24,535	\$		\$ 153,428	75

D. Vehicle Costs. (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	2003 FORD	2009	\$ 4,995	\$	\$	\$		\$ 4,995	76
77	PATIENT TRANSPORT	2013 FORD	2014	36,753	6,616	6,616		5 YRS.	30,321	77
78	PATIENT TRANSPORT	2017 FORD	2017	56,852	7,310	7,310		7 YRS.	10,356	78
79										79
80	TOTALS			\$ 98,600	\$ 13,926	\$ 13,926	\$		\$ 45,672	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)	\$ 2,347,705	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,933	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,933	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)	\$ 1,301,371	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	(4) COTTAGES	\$ 489,994	\$ 16,161	\$ 327,138	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 489,994	\$ 16,161	\$ 327,138	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	<b>TOTAL</b>				\$ _____			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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10-3B	hrs	\$	3,978	\$ 70,328	\$ 364	3,978	\$ 70,692	1
2	Licensed Speech and Language Development Therapist	10-3B	hrs		54	3,580		54	3,580	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3B	hrs		4,684	91,982		4,684	91,982	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	8,716	\$ 165,890	\$ 364	8,716	\$ 166,254	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.

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

As of **10-31-18**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 96,641	\$ 96,641	1
2	Cash-Patient Deposits	4,189	4,189	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,258 )	894,575	894,575	3
4	Supply Inventory (priced at COST )	6,846	6,846	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,472	7,472	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,009,723	\$ 1,009,723	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	73,695	73,695	13
14	Buildings, at Historical Cost	2,266,086	2,266,086	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	336,575	336,575	16
17	Accumulated Depreciation (book methods)	(1,466,416)	(1,466,416)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,209,940	\$ 1,209,940	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,219,663	\$ 2,219,663	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 381,898	\$ 381,898	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,550	2,550	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,598	103,598	30
31	Accrued Taxes Payable (excluding real estate taxes)	68,608	68,608	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,109	4,109	32
33	Accrued Interest Payable	5,842	5,842	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 566,605	\$ 566,605	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	330,245	330,245	39
40	Mortgage Payable	1,266,799	1,266,799	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,597,044	\$ 1,597,044	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,163,649	\$ 2,163,649	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 56,014	\$ 56,014	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,219,663	\$ 2,219,663	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>226,704</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>226,704</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(170,690)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(170,690)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>56,014</b>	<b>24</b> *

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

Facility Name & ID Number NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning: 11-01-17

Ending: 10-31-18

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,175,520	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,175,520	3
<b>B. Ancillary Revenue</b>			
4	Day Care	10,296	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	4,865	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 15,161	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	400	12
13	Barber and Beauty Care	9,699	13
14	Non-Patient Meals	11,052	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	53,573	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	7,882	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 82,606	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	79,723	24
25	Interest and Other Investment Income***	27	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 79,750	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,353,037	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	606,991	31
32	Health Care	1,812,196	32
33	General Administration	757,536	33
<b>B. Capital Expense</b>			
34	Ownership	214,176	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,591	35
36	Provider Participation Fee	112,331	36
<b>D. Other Expenses (specify):</b>			
37	<b>FINES AND PENALTIES</b>	7,906	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,523,727	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(170,690)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (170,690)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,238,834	44
45	Private Pay - Net Inpatient Revenue	1,355,253	45
46	Medicare - Net Inpatient Revenue	581,433	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,175,520	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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, INC.

# 0020925

Report Period Beginning:

11-01-17

Ending:

10-31-18

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	2,088	\$ 78,577	\$ 37.63	1
2	Assistant Director of Nursing	1,563	41,040	26.26	2
3	Registered Nurses	15,726	344,924	21.93	3
4	Licensed Practical Nurses	17,414	297,561	17.09	4
5	CNAs & Orderlies	38,171	418,672	10.97	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,024	25,918	12.81	9
10	Activity Assistants	4,892	44,103	9.02	10
11	Social Service Workers	2,605	33,417	12.83	11
12	Dietician				12
13	Food Service Supervisor	2,148	42,893	19.97	13
14	Head Cook				14
15	Cook Helpers/Assistants	1,957	19,434	9.93	15
16	Dishwashers	14,048	134,973	9.61	16
17	Maintenance Workers	4,324	65,724	15.20	17
18	Housekeepers	5,235	48,435	9.25	18
19	Laundry	6,296	79,068	12.56	19
20	Administrator	2,080	76,703	36.88	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	9,601	166,931	17.39	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 C: <u>TRANSPORATIO</u>	2,221	25,187	11.34	32
33	Other(specify) <u>BEAUTY SHOP</u>	995	11,376	11.43	33
34	TOTAL (lines 1 - 33)	133,388	\$ 1,954,936 *	\$ 14.66	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	111	\$ 5,486	1.3	35
36	Medical Director	44	11,440	9-3	36
37	Medical Records Consultant	37	2,599	10-3	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)	192	\$ 19,525		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	
DEBORAH HULL	ADMINISTRATOR	0	76,703	Workers' Compensation Insurance	109,855	IDPH License Fee	1,990	
				Unemployment Compensation Insurance	7,488	Advertising: Employee Recruitment	2,804	
				FICA Taxes	149,145	Health Care Worker Background Check (Indicate # of checks performed <u>14</u> )	560	
				Employee Health Insurance	77,616	Patient Background Checks	616	
				Employee Meals		MARKETING	6,880	
				Illinois Municipal Retirement Fund (IMRF)*		COLLECTION EXPENSE	0	
				LIFE ISURANCE	4,644	SUBSCRIPTIONS	879	
				401K PLAN	11,204	DUES - OTHER	6,785	
						employees public relations	2,134	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,703			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 359,952	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,648	
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
STAFF & STAFF	LEGAL		4,484				Out-of-State Travel	\$
DENNIS KOCH	ACCOUNTING		14,500					
TEMPLIN	ACCOUNTING		2,270				In-State Travel	133
KLINGER & ASSOCIATES	ENGINEERS		3,350					
							Seminar Expense	969
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 24,604	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,102

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number NORTH ADAMS HOME, INC.

# 0020925

Report Period Beginning: 11-01-17

Ending: 10-31-18

**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?  
If YES, give association name and amount. ILINOIS HEALTH CARE (IHCA)
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,136 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES XX NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO XX 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. \$ 112,331  
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. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 4,646  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained?  
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: DENNIS KOCH
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees