

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

I. IDPH Facility ID Number: 0014399

Facility Name: Grange Nursing Home

Address: 901 North Tenth Street Mascoutah 62258
 Number City Zip Code

County: St. Clair

Telephone Number: (618) 566-2183 **Fax #** (618) 566-4462

IDPA ID Number: 370855394001

Date of Initial License for Current Owners: 04/07/64

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501(C)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Clara Mae Wilhelm **Telephone Number:** (618) 566-4743
Accountant

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

(Signed) _____ 3/28/06
 (Date)

Officer or Administrator of Provider
 (Type or Print Name) Kenneth A. Joseph
 (Title) President

(Signed) _____
 (Date)

Paid Preparer
 (Print Name and Title) _____
 (Firm Name & Address) _____
 (Telephone) () _____ Fax # () _____

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Grange Nursing Home

0014399 Report Period Beginning: 1/1/2005 Ending: 12/31/05

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	55	Skilled (SNF)	55	20,075	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	55	TOTALS	55	20,075	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	1,083	513	756	2,352	8
9	SNF/PED					9
10	ICF	6,301	3,357		9,658	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,384	3,870	756	12,010	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.83%

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

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 4/07/64

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 9 and days of care provided 756

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: _____

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

Facility Name & ID Number Grange Nursing Home # 0014399 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	69,593	1,831	4,716	76,140		76,140		76,140			1
2	Food Purchase		41,223		41,223		41,223		41,223			2
3	Housekeeping	68,103	4,571	120	72,794		72,794		72,794			3
4	Laundry	28,047	3,846		31,893		31,893		31,893			4
5	Heat and Other Utilities			47,298	47,298		47,298		47,298			5
6	Maintenance	21,514	8,622	12,649	42,785		42,785		42,785			6
7	Other (specify):*											7
8	TOTAL General Services	187,257	60,093	64,783	312,133		312,133		312,133			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	518,088	40,430	39,595	598,113		598,113		598,113			10
10a	Therapy											10a
11	Activities	22,379	1,195	1,022	24,596		24,596	(155)	24,441			11
12	Social Services	18,147	252	3,350	21,749		21,749		21,749			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	558,614	41,877	46,967	647,458		647,458	(155)	647,303			16
	C. General Administration											
17	Administrative	41,354			41,354		41,354		41,354			17
18	Directors Fees											18
19	Professional Services			38,882	38,882		38,882		38,882			19
20	Dues, Fees, Subscriptions & Promotions			4,628	4,628		4,628	(1,038)	3,590			20
21	Clerical & General Office Expenses	28,139	5,637	3,104	36,880		36,880		36,880			21
22	Employee Benefits & Payroll Taxes			126,180	126,180		126,180		126,180			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,482	1,482		1,482		1,482			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,082	21,082		21,082		21,082			26
27	Other (specify):*											27
28	TOTAL General Administration	69,493	5,637	195,358	270,488		270,488	(1,038)	269,450			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	815,364	107,607	307,108	1,230,079		1,230,079	(1,193)	1,228,886			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 Grange Nursing Home #0014399 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			41,606	41,606		41,606		41,606			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,256	2,256		2,256	(416)	1,840			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,866	1,866		1,866		1,866			35
36	Other (specify):* Mortgage Ins			747	747		747		747			36
37	TOTAL Ownership			46,475	46,475		46,475	(416)	46,059			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,723	51,094	68,817		68,817		68,817			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,155	30,155		30,155		30,155			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		17,723	81,249	98,972		98,972		98,972			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	815,364	125,330	434,832	1,375,526		1,375,526	(1,609)	1,373,917			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 Grange Nursing Home

0014399

Report Period Beginning: 1/1/2005

Ending: #####

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				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	(416)			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				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	(431)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(327)	20		28
29	Other-Attach Schedule	(215)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,389)		\$	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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,389)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

Grange Nursing Home

ID# 0014399
 Report Period Beginning: 1/1/2005
 Ending: 12/31/2005

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Detail for line 29	\$		1
2	Eliminate Chamber of Commerce Dues	(60)	20/2	2
3				3
4	Eliminate Contribution and Activity Expense	(155)	11/2	4
5				5
6	Eliminate Public Relations Expense	(431)	20/2	6
7				7
8	Eliminate Non-allowable advertising	(220)	20/2	8
9				9
10	Eliminate Yellow Page advertising	(327)	20/2	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	(1,193)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grange Nursing Home# 0014399

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(155)	0	0	0	0	0	0	0	0	0	0	(155)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(155)	0	0	0	0	0	0	0	0	0	0	(155)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,038)	0	0	0	0	0	0	0	0	0	0	(1,038)	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):* Interest	(416)	0	0	0	0	0	0	0	0	0	0	(416)	27
28	TOTAL General Administration	(1,454)	0	0	0	0	0	0	0	0	0	0	(1,454)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,609)	0	0	0	0	0	0	0	0	0	0	(1,609)	29

STATE OF ILLINOIS

Facility Name & ID Number Grange Nursing Home

0014399

Report Period Beginning:

1/1/05

Ending:

Summary B

12/31/05

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	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	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,609)	0	0	0	0	0	0	0	0	0	0	(1,609)	45

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 Grange Nursing Home # 0014399 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

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	KENNETH A. JOSEPH	PRESIDENT	BOARD MEMBER						\$	1	
2	WILLIAM WOODS	SEC/TREAS	BOARD MEMBER							2	
3	SOPHIE TRESER		BOARD MEMBER							3	
4	DON SCHAEFFER		BOARD MEMBER							4	
5	MILDRED MEINKOTH		BOARD MEMBER							5	
6	JAMES ECKERT		BOARD MEMBER							6	
7										7	
8										8	
9										9	
10										10	
11	THE BORAD OF DIRECTORS DO NOT PROVIDE DIRECT SERVICE TO THE FACILITY OR RECEIVE COMPENSATION										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 Grange Nursing Home

0014399

Report Period Beginning: 1/1/2005

Ending: #####

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	Citizens Community Bank		X	Cash Flow		7/1/05	44,000		60 Day	7.2500	367						
7	Citizens Community Bank		X	Cash Flow		7/15/05	15,000		60 Day	7.2500	166						
8	Citizens Community Bank		X	Cash Flow		8/31/05	60,183	102,183	12 Month	7.3500	1,723						
9	TOTAL Facility Related						\$ 119,183	\$ 102,183			\$ 2,256						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 119,183	\$ 102,183			\$ 2,256						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 747 Line # 36

* 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

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2000	_____	8		
2001	_____	9		
2002	_____	10		
2003	_____	11		
2004	_____	12		
			FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2004	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grange Nursing Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0014399

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Grange Nursing Home# 0014399 Report Period Beginning:1/1/2005 Ending:12/31/2005**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 17,712 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

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

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

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

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>CARE FACILITY</u>	<u>30,000</u>	<u>1962</u>	<u>\$ 1,064</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	30,000		\$ 1,064	3

Facility Name & ID Number Grange Nursing Home

0014399

Report Period Beginning:

1/1/05

Ending:

12/31/05

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	29		1963	1963	\$ 125,662	\$ 2,513	50	\$ 2,513		\$ 106,953	4
5	26		1969	1969	148,564	3,714	40	3,714		133,398	5
6											6
7											7
8											8
	Improvement Type**										
9		Sewer & water		1964	7,560	151	50	151		6,324	9
10		Sprinkler		1975	27,550		20			27,550	10
11		Sprinkler		1977	840		20			840	11
12		Smoke Detector		1976	6,485		10			6,485	12
13		Solarium		1979	26,719	405	15	405		26,719	13
14		Solarium Improvements		1983	500		25			500	14
15		Seamless Floor		1982	2,008		7			2,008	15
16		Heating & Cooling		1985	36,010	890	20	890		36,010	16
17		New Roof		1985	24,000		15			24,000	17
18		Insulation		1985	3,980		15			3,980	18
19		Sprinkler		1985	2,187	21	20	21		2,187	19
20		Building Addition		1987	272,812	10,104	27	10,104		186,248	20
21		Skylights		1988	1,790	90	20	90		1,587	21
22		Windows		1988	1,138	57	20	57		969	22
23		Bathroom Remodeling		1989	10,065	503	20	503		8,386	23
24		Chair Rails		1989	441		10			441	24
25		Shutoff Valves		1990	3,045	152	20	152		2,396	25
26		Door Alarm & Air Conditioners		1990	2,425		10			2,425	26
27		Heat Pump & Awning		1993	4,577		10			4,577	27
28		Fence		1993	2,931	146	20	146		1,787	28
29		Sprinklers, Keypad to Patio Doors		1994	1,267	63	20	63		733	29
30		Sidewalks, Trees		1994	13,361	668	20	668		7,628	30
31		Activity Doors, Coder Alert, Door Alarm		1994	5,346		10			5,346	31
32		Awning, Exhaust Fans		1994	6,204		10			6,204	32
33		Courtyard		1996	7,310	487	15	487		4,627	33
34		Soiled Utility Room		1996	6,751	450	15	450		4,275	34
35		30% Downpayment on Fire Alarm System		1997	2,573	129	20	129		1,225	35
36		Balance of Fire Alarm System		1997	6,226	311	20	311		2,644	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 Grange Nursing Home

0014399

Report Period Beginning:

1/1/05

Ending:

12/31/05

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	Hot Water Heater & Installation	1997	\$ 3,476	\$ 348	10	\$ 348	\$	\$ 2,958	37
38	New Sprinkler & Installation	1997	4,618	184	25	184		1,571	38
39	Electrical Worklights in Garden Area	1997	1,402	70	20	70		595	39
40	Labor/Materials for Shower Renovations	1997	2,112	141	15	141		1,198	40
41	Labor/Materials for New Offices	1997	10,764	718	15	718		6,103	41
42	Hot Water Boiler	1997	2,800	140	20	140		1,190	42
43	Carpet for Wall Throughout the Facility	1997	1,488	99	15	99		842	43
44	Labor/Materials for Nurses Station Office Renovation	1998	10,151	1,015	10	1,015		7,613	44
45	Retubing Boiler	1998	2,530	253	10	253		1,898	45
46	Install Annunziator Panel	1998	402	21	19	21		168	46
47	Install Air Handler	1999	2,900	145	20	145		943	47
48	Labor/Materials to Paint, Wall Paper for Dining Room	1999	2,628	263	10	263		1,709	48
49	Top Dress Rock Areas of Parking Lot with Rock	2001	1,900	380	5	380		1,710	49
50	Demolish/Rebuild 2 Distinct Bathrooms	2001	26,134	2,614	10	2,614		11,760	50
51	Install Air Compressor for Sprinkler System	2002	1,519	152	10	152		532	51
52	Relocate 3 Heat Lines & Replace Concrete Floor in Laundry	2002	4,674	468	10	468		1,636	52
53	Labor/Material for Renovate North Hall Bathrooms	2002	2,749	275	10	275		962	53
54	Completely Demolish/Rebuild South Hall Bathrooms	2002	14,902	1,490	10	1,490		5,215	54
55	Repair Kitchen Drains/Install 250 Gal Concrete Grease Trap	2002	11,009	1,101	10	1,101		3,853	55
56	Remodeled Bookkeeper's Office-Cabinets, Walls, Floor, ceiling	2002	2,160	216	10	216		756	56
57	Remodeled Solarium-New Floor, Walls, Ceiling, Windows	2002	8,342	834	10	834		2,919	57
58	Remodeled Bathrooms-New Showers, Toilets, Cabinets, walls	2003	23,086	2,309	10	2,309		5,772	58
59	Install Wanderer Door Alarm System	2004	3,329	333	10	333		499	59
60	Repair Roof E-side of N-Wing & N-side of E-Wing	2004	8,326	555	15	555		833	60
61	Install Fire Wall in Attic	2005	1,793	10	15	10		10	61
62	Replace Furnace Heat Pump	2005	2,904	113	15	113		113	62
63	Move Sprinklers Per Code	2005	1,900	11	15	11		11	63
64	Repair Another Heat Pump	2005	2,400	20	10	20		20	64
65	Install Pull Station in Vestibule	2005	2,041	187	10	187		187	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 924,766	\$ 35,319		\$ 35,319	\$	\$ 682,028	70

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

Facility Name & ID Number Grange Nursing Home # 0014399 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

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	\$ 57,217	\$ 6,144	\$ 6,144	\$		\$ 34,467	71
72	Current Year Purchases	6,563	143	143			143	72
73	Fully Depreciated Assets	245,312					245,312	73
74								74
75	TOTALS	\$ 309,092	\$ 6,287	\$ 6,287	\$		\$ 279,922	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)	\$ 1,234,922	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,606	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,606	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)	\$ 961,950	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 1,866 Description: Dish Machine (1,443) Patient Bed (423)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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		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.

Facility Name & ID Number Grange Nursing Home# 0014399

Report Period Beginning:

1/1/05

Ending:

12/31/05

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3	hrs	\$	228	\$ 16,751	\$	228	\$ 16,751	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		31	2,073		31	2,073	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		398	29,510		398	29,510	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				17,723		17,723	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-RAY & LAB	39/3				2,760			2,760	13
14	TOTAL			\$	657	\$ 51,094	\$ 17,723	657	\$ 68,817	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 Grange Nursing Home# 0014399Report Period Beginning: 1/1/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ (15,626)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	286,679		3
4	Supply Inventory (priced at <u>Cost</u>)	11,058		4
5	Short-Term Investments	23,848		5
6	Prepaid Insurance	14,707		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)	\$ 320,666	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,064		13
14	Buildings, at Historical Cost	927,599		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	306,258		16
17	Accumulated Depreciation (book methods)	(961,951)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 272,970	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 593,636	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 40,704	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	102,183		29
30	Accrued Salaries Payable	21,404		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,168		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 173,459	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 173,459	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 420,177	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 593,636	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 550,745	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 550,745	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(130,568)	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)	\$ (130,568)	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)	\$ 420,177	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Grange Nursing Home# 0014399Report Period Beginning: 1/1/05Ending: 12/31/05**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	\$ 1,189,484	1
2	Discounts and Allowances for all Levels	(2,720)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,186,764	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	23,594	6
7	Oxygen	20,501	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 44,095	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,517	19
20	Radiology and X-Ray	225	20
21	Other Medical Services	404	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,146	23
D. Non-Operating Revenue			
24	Contributions	11,537	24
25	Interest and Other Investment Income***	416	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,953	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,244,958	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	312,133	31
32	Health Care	647,458	32
33	General Administration	270,488	33
B. Capital Expense			
34	Ownership	46,475	34
C. Ancillary Expense			
35	Special Cost Centers	68,817	35
36	Provider Participation Fee	30,155	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,375,526	40
41	Income before Income Taxes (line 30 minus line 40)**	(130,568)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (130,568)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Grange Nursing Home

0014399

Report Period Beginning:

1/1/05

Ending:

12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	2,159	41,489	18.00	3
4	Licensed Practical Nurses	8,377	144,991	16.18	4
5	CNAs & Orderlies	32,651	331,608	9.59	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,205	22,379	10.01	9
10	Activity Assistants				10
11	Social Service Workers	997	18,147	14.73	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	8,863	69,593	7.51	15
16	Dishwashers				16
17	Maintenance Workers	1,655	21,514	11.41	17
18	Housekeepers	5,603	68,103	10.68	18
19	Laundry	3,148	28,047	8.28	19
20	Administrator	1,992	41,354	19.81	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,897	28,139	13.12	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)				33
34	TOTAL (lines 1 - 33)	69,547	\$ 815,364 *	\$ 10.95	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	100	\$ 4,716	1/3 35
36	Medical Director		3,000	9/3 36
37	Medical Records Consultant	11	385	10/3 37
38	Nurse Consultant			38
39	Pharmacist Consultant		600	10/3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	11	817	11/3 44
45	Social Service Consultant	13	918	12/3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	135	\$ 10,436	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	1,638	33,891	10/3 51
52	Certified Nurse Assistants/Aides	257	4,719	10/3 52
53	TOTAL (lines 50 - 52)	1,895	\$ 38,610	53

Facility Name & ID Number Grange Nursing Home

0014399

Report Period Beginning: 1/1/05

Ending: 12/31/05

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			
Sheila Storey	Administrator	0	\$ 41,354	Workers' Compensation Insurance	\$ 42,675	IDPH License Fee	\$ 995			
				Unemployment Compensation Insurance	15,742	Advertising: Employee Recruitment	2,112			
				FICA Taxes	63,851	Health Care Worker Background Check	352			
				Employee Health Insurance	1,200	(Indicate # of checks performed <u>22</u>)				
				Employee Meals		IL Nursing Home License	100			
				Illinois Municipal Retirement Fund (IMRF)*		Sam's Club(30),Creative Forecasting(48)	78			
				Grange insignia on smocks	876	Chamber of Com(60),NAGNA (275)	335			
				Recognitions, Food, Misc	1,836	Corp Fees(5)	5			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 41,354	TOTAL (agree to Schedule V, line 22, col.8)			\$ 126,180	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,590
(List each licensed administrator separately.)										
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount		
	\$					\$	Out-of-State Travel	\$		
							In-State Travel			
							Reimburse mileage	657		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,482
(Attach a copy of any management service agreement)										
C. Professional Services										
Vendor/Payee	Type	Amount								
Jamestown Mgmt Corp	Management	\$ 32,407								
MD Services	Computer	1,080								
Freestone Computing	Computer	450								
RAU & RAU	Legal	570								
Richard Breslin	Accountant	335								
Collier Appraiser	Appraisal	2,000								
Chicago Tital	Loan	581								
M.E.S.	Purchasing	169								
Accu-Med Services	Computer	1,290								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 38,882							
(If total legal fees exceed \$2500 attach copy of invoices.)										

* Attach copy of IMRF notifications

**See instructions.

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? No
If YES, give association name and amount. _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO 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. \$ 30,155
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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A 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? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
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? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

The Grange Nursing Home

#0014399

1/1/2005

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Page 7 Schedule VII.

Related Parties

Administrator

Sheila Storey

Board of Directors

Kenneth A. Joseph
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Lebanon, IL 62254-1823
(618) 632-4491

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(618) 632-5715

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