

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License 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

HFS ID Number: 370855394001

Date of Initial License for Current Owners: 04/07/1964

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) 566-2183

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2007 to 12/31/2007 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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Kenneth A. Joseph</u>	
	(Title) <u>President</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(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: 1/1/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 04/01/2007

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>55</u>	TOTALS	<u>55</u>	<u>20,075</u>	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	<u>365</u>	<u>323</u>	<u>2,058</u>	<u>2,746</u>	8
9	SNF/PED					9
10	ICF	<u>7,560</u>	<u>4,079</u>		<u>11,639</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,925</u>	<u>4,402</u>	<u>2,058</u>	<u>14,385</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.66%

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)

NoneF. 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 4/7/1964

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 55 and days of care provided 2,058Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Grange Nursing Home # 0014399 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	88,724	4,044	6,077	98,845		98,845	98,845			1
2	Food Purchase		58,972		58,972		58,972	58,972			2
3	Housekeeping	69,689	6,368		76,057		76,057	76,057			3
4	Laundry	25,745	7,999		33,744		33,744	33,744			4
5	Heat and Other Utilities			60,273	60,273		60,273	60,273			5
6	Maintenance	16,727	7,705	13,118	37,550		37,550	37,550			6
7	Other (specify):*										7
8	TOTAL General Services	200,885	85,088	79,468	365,441		365,441	365,441			8
	B. Health Care and Programs										
9	Medical Director			2,750	2,750		2,750	2,750			9
10	Nursing and Medical Records	591,693	58,002	199,944	849,639		849,639	849,639			10
10a	Therapy			261,699	261,699		261,699	261,699			10a
11	Activities	15,390	2,224	1,394	19,008		19,008	19,008			11
12	Social Services	31,288		699	31,987		31,987	31,987			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	638,371	60,226	466,486	1,165,083		1,165,083	1,165,083			16
	C. General Administration										
17	Administrative	43,661			43,661		43,661	43,661			17
18	Directors Fees										18
19	Professional Services			7,795	7,795		7,795	7,795			19
20	Dues, Fees, Subscriptions & Promotions			8,948	8,948		8,948	(4,588)	4,360		20
21	Clerical & General Office Expenses	34,427	6,899	531	41,857		41,857	41,857			21
22	Employee Benefits & Payroll Taxes			117,297	117,297		117,297	117,297			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,222	1,222		1,222	1,222			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,686	39,686		39,686	39,686			26
27	Other (specify):*										27
28	TOTAL General Administration	78,088	6,899	175,479	260,466		260,466	(4,588)	255,878		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	917,344	152,213	721,433	1,790,990		1,790,990	(4,588)	1,786,402		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: 1/1/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			42,601	42,601	42,601		42,601			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			10,802	10,802	10,802	(4)	10,798			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			2,914	2,914	2,914		2,914			35
36	Other (specify):*										36
37	TOTAL Ownership			56,317	56,317	56,317	(4)	56,313			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		69,485	9,815	79,300	79,300		79,300			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			27,764	27,764	27,764		27,764			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		69,485	37,579	107,064	107,064		107,064			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	917,344	221,698	815,329	1,954,371	1,954,371	(4,592)	1,949,779			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: 1/1/2007

Ending: 12/31/2007

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				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	(4)	32/7		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	(4,201)	20/7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(234)	20/7		28
29	Other-Attach Schedule Schedule PG5A	(153)	20/7		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,592)		\$	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))	\$ (4,592)		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

BHF USE ONLY						
48		49		50		51
						52

Grange Nursing Home

ID# 0014399
 Report Period Beginning: 1/1/2007
 Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Mascoutah Chamber Dues	\$ (60)	29 1
2	Mascoutah Rotary	(40)	29 2
3	St. Clair County	(18)	29 3
4	Sam's Wholesale Club	(35)	29 4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(153)	49

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
N/A						

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		\$	N/A		\$	\$	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: 1/1/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Kenneth A. Joseph	President	Board Member	None	None	<1	0.01		\$ 0	1	
2	Don Schaeffer	Treasurer	Board Member	None	None	<1	0.01		0	2	
3	Sophie Treser	Secretary	Board Member	None	None	<1	0.01		0	3	
4	Mildred Meinkoth	Director	Board Member	None	None	<1	0.01		0	4	
5	James Eckert	Director	Board Member	None	None	<1	0.01		0	5	
6	William Woods	Director	Board Member	None	None	<1	0.01		0	6	
7										7	
8										8	
9										9	
10	The Board of Directors do not provide direct service to the facility or receive compensation.										10
11											11
12											12
13								TOTAL	\$ 0		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: 1/1/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3			N/A						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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Citizens Community Bank		X	Cash Flow		8/31/07	191,171	250,000	8/31/08	Variable	10,803	6
7	Citizens Community Bank		X	Cash Flow		12/28/07	11,000	11,000	4/28/08	0.0800		7
8												8
9	TOTAL Facility Related						\$ 202,171	\$ 261,000			\$ 10,803	9
	B. Non-Facility Related*											
10								Interest income offset			(4)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			(4)	14
15	TOTALS (line 9+line14)						\$ 202,171	\$ 261,000			\$ 10,799	15

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grange Nursing Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0014399

CONTACT PERSON REGARDING THIS REPORT Clara Mae Wilhelm

TELEPHONE (618) 566-2341 FAX #: (618) 566-4220

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Grange Nursing Home

0014399 Report Period Beginning:

1/1/2007 Ending: 12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,712 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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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>	1
2					2
3	TOTALS	30,000		\$ 1,064	3

Facility Name & ID Number Grange Nursing Home

0014399

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

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

	1 Beds*	FOR BHF 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		\$ 111,980	4
5	26		1969	1969	148,564	3,714	40	3,714		140,826	5
6											6
7											7
8											8
		Improvement Type**									
9		Sewer & Water		1964	7,560	151	50	151		6,627	9
10		Sprinkler		1975	27,550		20			27,550	10
11		Sprinkler		1977	840		20			840	11
12		Smoke Detector		1976	6,484		10			6,485	12
13		Exterior Lighting		1978	1,019		10			1,019	13
14		Solarium		1979	26,719		25			26,719	14
15		Solarium Improvements		1983	500		25			500	15
16		Seamless Floor		1982	2,008		10			2,008	16
17		Heating & Cooling		1985	36,010		20			36,010	17
18		New Roof		1985	24,000		15			24,000	18
19		Insulation		1985	3,980		15			3,980	19
20		Sprinkler		1985	2,187		20			2,187	20
21		Building Addition		1987	272,812	10,104	27	10,104		206,456	21
22		Skylights		1988	1,790	90	20	90		1,765	22
23		Windows		1988	1,138	57	20	57		1,083	23
24		Bathroom Remodeling		1989	10,065	503	20	503		9,393	24
25		Outside Aluminium Shed		1989	1,815		10			1,815	25
26		Chair Rails		1989	441		10			441	26
27		Shutoff Valves		1990	3,045	152	20	152		2,701	27
28		Door Alarm & Air Conditioners		1990	2,425		10			2,425	28
29		Heat Pump & Awning		1993	4,577		10			4,577	29
30		Fence		1993	2,931	147	20	147		2,080	30
31		Sprinklers, Keypad to Patio Doors		1994	1,267	63	20	63		860	31
32		Sidewalks, Trees		1994	13,361	668	20	668		8,964	32
33		Activity Doors, Coder Alert, Door Alarm		1994	5,346		10			5,346	33
34		Awning, Exhaust Fans		1994	6,204		10			6,204	34
35		Courtyard		1996	7,310	487	15	487		5,602	35
36		Soiled Utility Room		1996	6,751	450	15	450		5,175	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:

1/1/2007

Ending:

12/31/2007

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	30% Downpayment on Fire Alarm System	1996	\$ 2,573	\$ 129	20	\$ 129	\$	\$ 1,482	37
38	Balance of Fire Alarm System	1997	6,226	311	20	311		3,267	38
39	Hot Water Heater & Installation	1997	3,476	171	10	171		3,476	39
40	New Sprinkler & Installation	1997	4,618	185	25	185		1,941	40
41	Electrical Worklights in Garden Area	1997	1,402	70	20	70		735	41
42	Labor/Materials for Shower Renovations	1997	2,112	141	15	141		1,479	42
43	Labor/Materials for New Offices	1997	10,764	718	15	718		7,537	43
44	Hot Water Boiler	1997	2,800	140	20	140		1,470	44
45	Carpet for Wall Throughout the Facility	1997	1,488	99	15	99		1,041	45
46	Labor/Materials for Nurses Station Office Renovation	1998	10,151	1,015	10	1,015		9,643	46
47	Retubing Boiler	1998	2,530	253	10	253		2,404	47
48	Install Annunziator Panel	1998	402	21	19	21		211	48
49	Install Air Handler	1999	2,900	145	20	145		1,233	49
50	Labor/Materials to Paint, Wall Paper for Dining Room	1999	2,628	263	10	263		2,234	50
51	Top Dress Rock Areas of Parking Lot with rock	2001	1,900		5			1,900	51
52	Demolish/Rebuild 2 distinct bathrooms	2001	26,134	2,613	10	2,613		16,987	52
53	Install Air Compressor for sprinkler system	2002	1,519	152	10	152		835	53
54	Relocate 3 heat lines & replace concrete floor in laundry	2002	4,674	467	10	467		2,571	54
55	Labor/Material for renovate north hall bathrooms	2002	2,749	275	10	275		1,512	55
56	Completely demolish/Rebuild south hall bathrooms	2002	14,902	1,490	10	1,490		8,196	56
57	Repair Kitchen drains/Install 250 Gal concrete grease trap	2002	11,009	1,101	10	1,101		6,055	57
58	Remodel Bookkeeper's office-cabinets, walls, floor, ceiling	2002	2,160	216	10	216		1,188	58
59	Remodel solarium-New floor, walls, ceiling, windows	2002	8,342	834	10	834		4,588	59
60	Remodel bathrooms-new showers, toilets, cabinets, walls	2003	23,086	2,309	10	2,309		10,389	60
61	Install wanderer door alarm system	2004	3,329	333	10	333		1,165	61
62	Repair roof E-side of N-wing & N-side of E-wing	2004	8,326	555	15	555		1,943	62
63	Install fire wall in attic	2005	1,793	120	15	120		249	63
64	Replace furnace heat pump	2005	2,904	194	15	194		500	64
65	Move sprinklers - per code	2005	1,900	127	15	127		264	65
66	Repair another heat pump	2005	2,400	240	10	240		500	66
67	Install pull station in vestibule	2005	2,041	204	10	204		595	67
68	Replace roof - SW side	2007	5,800	97	15	97		97	68
69	South wing escape sidewalk	2007	2,600	72	15	72		72	69
70	TOTAL (lines 4 thru 69)		\$ 935,999	\$ 34,159		\$ 34,159	\$	\$ 753,377	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: 1/1/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 66,007	\$ 8,249	\$ 8,249	\$	10	\$ 41,263	71
72	Current Year Purchases	3,313	193	193		10	193	72
73	Fully Depreciated Assets	251,996					251,996	73
74								74
75	TOTALS	\$ 321,316	\$ 8,442	\$ 8,442	\$		\$ 293,452	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	N/A			\$	\$	\$	\$		\$	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)	\$ 1,258,379	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,601	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,601	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)	\$ 1,046,829	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

Facility Name & ID Number Grange Nursing Home

0014399

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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				N/A			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 2,914 Description: Dish Machine (\$2,137) and Lift Machine (\$ 777)

(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			N/A		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:

1/1/2007

Ending:

12/31/2007

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/A/3	hrs	\$	1,837	\$ 96,323	\$	1,837	\$ 96,323	1
2	Licensed Speech and Language Development Therapist	10/A/3	hrs		342	43,029		342	43,029	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10/A/3	hrs		2,528	122,347		2,528	122,347	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				69,485		69,485	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 work	39/3				9,815			9,815	13
14	TOTAL			\$	4,707	\$ 271,514	\$ 69,485	4,707	\$ 340,999	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: 1/1/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 21,257	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	818,095		3
4	Supply Inventory (priced at)	11,058		4
5	Short-Term Investments	9,625		5
6	Prepaid Insurance	13,598		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)	\$ 873,633	\$	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	935,999		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	321,316		16
17	Accumulated Depreciation (book methods)	(1,046,829)		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)	\$ 211,550	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,085,183	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 175,123	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	261,000		29
30	Accrued Salaries Payable	33,737		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,613		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	Unearned income	10,308		36
37	Employee ins & retirement	531		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 495,312	\$	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)	\$ 495,312	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 589,871	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,085,183	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 608,018	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 608,018	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(18,147)	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)	\$ (18,147)	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)	\$ 589,871	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Grange Nursing Home# 0014399Report Period Beginning: 1/1/2007Ending: 12/31/2007**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	\$ 1,894,036	1
2	Discounts and Allowances for all Levels	(4,266)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,889,770	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	9,988	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 9,988	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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	6,395	24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,399	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bad debts recovered	30,042	28
28a	Flu vaccination	25	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,067	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,936,224	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	365,441	31
32	Health Care	1,186,014	32
33	General Administration	239,535	33
B. Capital Expense			
34	Ownership	56,317	34
C. Ancillary Expense			
35	Special Cost Centers	79,300	35
36	Provider Participation Fee	27,764	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,954,371	40
41	Income before Income Taxes (line 30 minus line 40)**	(18,147)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (18,147)	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: 1/1/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,512	1,520	\$ 28,880	\$ 19.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,120	2,389	45,675	19.12	3
4	Licensed Practical Nurses	12,016	12,844	213,086	16.59	4
5	CNAs & Orderlies	28,661	30,799	304,052	9.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,856	1,933	15,390	7.96	10
11	Social Service Workers	1,908	2,115	31,288	14.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,754	1,892	15,120	7.99	14
15	Cook Helpers/Assistants	8,877	9,361	73,604	7.86	15
16	Dishwashers					16
17	Maintenance Workers	1,502	1,554	16,727	10.76	17
18	Housekeepers	5,935	6,575	69,689	10.60	18
19	Laundry	2,696	3,000	25,745	8.58	19
20	Administrator	1,822	2,039	43,661	21.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,989	2,158	31,808	14.74	23
24	Clerical	237	237	2,619	11.05	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)	72,885	78,416	\$ 917,344 *	\$ 11.70	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	124	\$ 6,077	1/3	35
36	Medical Director	Monthly	2,750	9/3	36
37	Medical Records Consultant	13	568	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	284	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	12	699	11/3	44
45	Social Service Consultant	12	699	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	161	\$ 11,077		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	4,420	115,203	10/3	51
52	Certified Nurse Assistants/Aides	3,717	83,889	10/3	52
53	TOTAL (lines 50 - 52)	8,137	\$ 199,092		53

Facility Name & ID Number Grange Nursing Home

0014399

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

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	1/1-7/1/07	Administrator	0	\$	22,730	Workers' Compensation Insurance	\$	23,066	IDPH License Fee	\$	995
Lynn Haas	7/1-12/31/07	Administrator	0		20,931	Unemployment Compensation Insurance		23,268	Advertising: Employee Recruitment		1,774
						FICA Taxes		69,788	Health Care Worker Background Check		1,080
						Employee Health Insurance		500	(Indicate # of checks performed <u>65</u>)		448
						Employee Meals		675	Patient Background Checks <u>28</u>		448
						Illinois Municipal Retirement Fund (IMRF)*			Public relations & direct advertising		4,435
									Creative Forecasting		48
									IL Charity Bureau		15
									Chamber, St. Clair County, etc		153
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$	43,661						
B. Administrative - Other											
Description					Amount						
				\$							
TOTAL (agree to Schedule V, line 17, col. 3)				\$							
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount			Description	Amount	
Accu-Med Services	Computer		\$ 2,915	N/A					Out-of-State Travel	\$	
James F. Ferris, Jr CPA	Audit		2,100								
McGladrey & Pullen	Accounting		2,680						In-State Travel		
WA Schickedanz Agency	Surety Bond		100						Reimburse mileage	807	
									Seminar Expense		
									INHAA	100	
									SWIC	180	
									LTC DON	135	
									Entertainment Expense	()	
									(agree to Sch. V,		
									line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				\$	7,795				TOTAL	\$	1,222
(If total legal fees exceed \$5,000, attach copy of invoices.)											

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Grange Nursing Home

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. N/A
- (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? N/A
- (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? N/A
- (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 years
- (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 X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N.A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 27,764
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? Yes 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? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- 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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: James F. Ferris, Jr CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. In progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

The Grange Nursing Home, Inc.

0014399

1/1/2007 - 12/31/2007

Employee

Lynn Haas	Wages
Page 3, Schedule V, Line # 17, Column 1	20,931
Page 3, Schedule V, Line # 10, Column 1	<u>19,732</u>
	<u><u>40,663</u></u>