



Facility Name & ID Number Grange Nursing Home

# 0014399 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>578</u>	<u>2,008</u>	<u>2,586</u>	8
9	SNF/PED					9
10	ICF	<u>8,413</u>	<u>4,202</u>		<u>12,615</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,413</u>	<u>4,780</u>	<u>2,008</u>	<u>15,201</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.72%

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 04/07/1964

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 2,008

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Grange Nursing Home # 0014399 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	114,643	7,452	5,213	127,308		127,308	127,308			1
2	Food Purchase		70,682		70,682		70,682	70,682			2
3	Housekeeping	71,896	7,166		79,062		79,062	79,062			3
4	Laundry	25,923	3,613		29,536		29,536	29,536			4
5	Heat and Other Utilities			74,312	74,312		74,312	74,312			5
6	Maintenance	23,650	7,458	15,869	46,977		46,977	46,977			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	236,112	96,371	95,394	427,877		427,877	427,877			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000	3,000			9
10	Nursing and Medical Records	724,603	45,084	116,504	886,191		886,191	886,191			10
10a	Therapy			273,434	273,434		273,434	273,434			10a
11	Activities	22,341	657	1,369	24,367		24,367	24,367			11
12	Social Services	31,296		660	31,956		31,956	31,956			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	778,240	45,741	394,967	1,218,948		1,218,948	1,218,948			16
	<b>C. General Administration</b>										
17	Administrative	45,136			45,136		45,136	45,136			17
18	Directors Fees										18
19	Professional Services			8,570	8,570		8,570	8,570			19
20	Dues, Fees, Subscriptions & Promotions			6,078	6,078		6,078	(3,170)	2,908		20
21	Clerical & General Office Expenses	66,677	7,055	5,226	78,958		78,958	78,958			21
22	Employee Benefits & Payroll Taxes			125,112	125,112		125,112	125,112			22
23	Inservice Training & Education										23
24	Travel and Seminar			3,792	3,792		3,792	3,792			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,210	38,210		38,210	38,210			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	111,813	7,055	186,988	305,856		305,856	(3,170)	302,686		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,126,165	149,167	677,349	1,952,681		1,952,681	(3,170)	1,949,511		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: 01/01/2008 Ending: 12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			42,695	42,695	42,695		42,695			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			16,757	16,757	16,757	(60)	16,697			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			770	770	770		770			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			60,222	60,222	60,222	(60)	60,162			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		58,410	6,981	65,391	65,391	(6,981)	58,410			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			35,105	35,105	35,105		35,105			42
43	Other (specify):* Code penalty,bad debt			39,622	39,622	39,622	(39,622)				43
44	<b>TOTAL Special Cost Centers</b>		58,410	81,708	140,118	140,118	(46,603)	93,515			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,126,165	207,577	819,279	2,153,021	2,153,021	(49,833)	2,103,188			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: 01/01/2008

Ending: 12/31/2008

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				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	(60)	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	(34,682)	43/7		24
25	Fund Raising, Advertising and Promotional	(1,594)	20/7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(366)	20/7		28
29	Other-Attach Schedule <u>PG 5A</u>	(13,131)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (49,833)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (49,833)		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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Grange Nursing Home

ID# 0014399

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Mascoutah Chamber of Commerce	\$ (60)	20/7	1
2	Illinois Secretary of State	(8)	20/7	2
3	Decorations for walls in facility	(156)	20/7	3
4	Notary Public Fee	(10)	20/7	4
5	Parade give aways	(976)	20/7	5
6	Penalty	(4,940)	43/7	6
7	X-ray and Lab costs	(6,981)	39/7	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(13,131)		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		\$			\$	\$	1
2	V			N/A				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: 01/01/2008 Ending: 12/31/2008

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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	\$		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: 01/01/2008

Ending: 2/31/2008

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	Citizens Community Bank		X	Cash Flow		8/31/08	250,000	213,600	8/31/09	Variable	13,957	6								
7	Citizens Community Bank		X	Cash Flow		12/25/08	35,000	35,000	3/25/09	0.0800	2,800	7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 285,000	\$ 248,600			\$ 16,757	9								
<b>B. Non-Facility Related*</b>																				
10							Interest income offset				(60)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (60)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 285,000	\$ 248,600			\$ 16,697	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.)

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2007 report.		\$	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$	3																																	
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>_____</td><td>8</td></tr> <tr><td>2004</td><td>_____</td><td>9</td></tr> <tr><td>2005</td><td>_____</td><td>10</td></tr> <tr><td>2006</td><td>_____</td><td>11</td></tr> <tr><td>2007</td><td>N/A</td><td>12</td></tr> </table>	2003	_____	8	2004	_____	9	2005	_____	10	2006	_____	11	2007	N/A	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2007	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2003	_____	8																																		
2004	_____	9																																		
2005	_____	10																																		
2006	_____	11																																		
2007	N/A	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	

NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <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>
<b>TOTALS</b>		\$ <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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Grange Nursing Home

# 0014399 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**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	<b>TOTALS</b>	<b>30,000</b>		<b>\$ 1,064</b>	<b>3</b>

Facility Name &amp; ID Number Grange Nursing Home

# 0014399

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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		\$ 114,493	4
5	26		1969	1969	148,564	3,714	40	3,714		144,540	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Sewer & Water		1964	7,560	151	50	151		6,778	9
10		Sprinkler		1975	27,550		20			27,550	10
11		Sprinkler		1977	840		20			840	11
12		Smoke Detector		1976	6,484		10			6,484	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 System		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		216,561	21
22		Skylights		1988	1,790	25	20	25		1,790	22
23		Windows		1988	1,138	55	20	55		1,138	23
24		Bathroom Remodeling		1989	10,065	503	20	503		9,896	24
25		Outside Aluminium shed		1989	1,815		10			1,815	25
26		Chair Rails		1989	441		10			441	26
27		Install Shutoff Valves		1990	3,045	152	20	152		2,853	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	146	20	146		2,227	30
31		Sprinklers, Keypad to Patio Doors		1994	1,267	63	20	63		924	31
32		Sidewalks & Trees		1994	13,361	668	20	668		9,632	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		6,090	35
36		Soiled Utility Room		1996	6,751	450	15	450		5,625	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 &amp; ID Number Grange Nursing Home

# 0014399

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	30% Downpayment on Fire Alarm System	1996	\$ 2,573	\$ 129	20	\$ 129	\$	\$ 1,610	37
38	Balance of Fire Alarm System	1997	6,226	311	20	311		3,579	38
39	Hot Water Heater & Installation	1997	3,476		10			3,476	39
40	New Sprinkler & Installation	1997	4,618	185	25	185		2,126	40
41	Electrical Worklights in Garden Area	1997	1,402	70	20	70		806	41
42	Labor/Materials for Shower Renovations	1997	2,112	141	15	141		1,620	42
43	Labor/Materials for New Offices	1997	10,764	718	15	718		8,255	43
44	Hot Water Boiler	1997	2,800	141	20	141		1,610	44
45	Carpet for Wall Throughout the Facility	1997	1,488	99	15	99		1,140	45
46	Labor/Materials for Nurses Station Office Renovation	1998	10,151	508	10	508		10,151	46
47	Retubing Boiler	1998	2,530	126	10	126		2,530	47
48	Install Annunziator Panel	1998	402	21	19	21		232	48
49	Install Aid Handler	1999	2,900	145	20	145		1,378	49
50	Labor/Materials to Paint, Wallpaper for Dining Room	1999	2,628	263	10	263		2,497	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		19,600	52
53	Install Air Compressor for Sprinkler System	2002	1,519	152	10	152		987	53
54	Relocate 3 heat lines & replace concrete floor in laundry	2002	4,674	467	10	467		3,038	54
55	Labor/Material for renovate north hall bathrooms	2002	2,749	275	10	275		1,787	55
56	Completely Demolish/Rebuild South Hall Bathrooms	2002	14,902	1,490	10	1,490		9,686	56
57	Repair Kitchen Drains/Install 250 Gal Concrete Grease Trap	2002	11,009	1,101	10	1,101		7,155	57
58	Remodel Bookkeeper's office-Cabinets, Walls, Floor, Ceiling	2002	2,160	216	10	216		1,404	58
59	Remodel Solarium-New Floor, Walls, Ceiling, Windows	2002	8,342	834	10	834		5,422	59
60	Remodel Bathrooms-New Showers, Toilets, Cabinets, Walls	2003	23,086	2,309	10	2,309		12,697	60
61	Install Wanderer Door Alarm System	2004	3,329	333	10	333		1,498	61
62	Repair Roof E-side of N-wing & N-side of E-wing	2004	8,326	555	15	555		2,498	62
63	Install Fire Wall in Attic	2005	1,793	120	15	120		368	63
64	Replacse Furnace Heat Pump	2005	2,904	194	15	194		694	64
65	Move Sprinklers - Per Code	2005	1,900	127	15	127		391	65
66	Repair Another Heat Pump	2005	2,400	240	10	240		740	66
67	Install Pull Station in Vestibule	2005	2,041	204	10	204		799	67
68	Replace roof -SW Side	2007	5,800	387	15	387		483	68
69	South Wing Escape Sidewalk	2007	2,600	173	15	173		246	69
70	TOTAL (lines 4 thru 69)		\$ 935,999	\$ 33,678		\$ 33,678	\$	\$ 787,055	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: 01/01/2008 Ending: 12/31/2008

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	\$ 63,791	\$ 8,018	\$ 8,018	\$	10	\$ 43,945	71
72	Current Year Purchases	6,592	999	999		7	999	72
73	Fully Depreciated Assets	237,015					237,015	73
74								74
75	TOTALS	\$ 307,398	\$ 9,017	\$ 9,017	\$		\$ 281,959	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)	\$ 1,244,461	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,695	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,695	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)	\$ 1,069,014	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: 01/01/2008

Ending: 12/31/2008

**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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	<u>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</u>	\$ _____

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: \$ 770

Description: Dish machine

(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			<u>N/A</u>		18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? The facility hires only trained CNA's</p> <p><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)	
<b>TOTAL TRAINED</b>	

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

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

Facility Name & ID Number Grange Nursing Home# 0014399 Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## 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	\$	5,619	\$ 103,147	\$	5,619	\$ 103,147	1
2	Licensed Speech and Language Development Therapist	10/A/3	hrs		730	32,547		730	32,547	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10/A/3	hrs		7,385	137,740		7,385	137,740	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 prescripts			58,410			58,410	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>X-ray &amp; Lab Work</u>	39/3				6,981			6,981	13
14	TOTAL			\$	13,734	\$ 338,825	\$	13,734	\$ 338,825	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 # 0014399 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,003	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	983,038		3
4	Supply Inventory (priced at <u>Cost</u> )	11,058		4
5	Short-Term Investments	9,625		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,166		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,022,890	\$	10
	<b>B. Long-Term Assets</b>			
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	307,398		16
17	Accumulated Depreciation (book methods)	(1,069,014)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 175,447	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,198,337	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 302,633	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	248,600		29
30	Accrued Salaries Payable	42,711		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,460		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Unearned income</u>	8,126		36
37	<u>Employee ins &amp; retirement</u>	760		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 605,290	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 605,290	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 593,047	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,198,337	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 589,871	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 589,871	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	3,176	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)	\$ 3,176	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 593,047	24 *

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

Facility Name & ID Number Grange Nursing Home# 0014399Report Period Beginning: 01/01/2008Ending: 12/31/2008**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,122,202	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,122,202	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	11,886	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 11,886	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,977	24
25	Interest and Other Investment Income***	60	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,037	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Bad debts recovered</b>	19,072	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 19,072	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,156,197	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	427,877	31
32	Health Care	1,218,948	32
33	General Administration	305,856	33
<b>B. Capital Expense</b>			
34	Ownership	60,222	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	105,013	35
36	Provider Participation Fee	35,105	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,153,021	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	3,176	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 3,176	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: 01/01/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	875	899	\$ 20,502	\$ 22.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,455	1,847	36,292	19.65	3
4	Licensed Practical Nurses	15,549	16,823	288,273	17.14	4
5	CNAs & Orderlies	33,710	36,524	379,536	10.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,247	2,395	22,341	9.33	9
10	Activity Assistants					10
11	Social Service Workers	1,835	2,130	31,296	14.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,821	1,877	21,560	11.49	14
15	Cook Helpers/Assistants	11,033	11,584	93,083	8.04	15
16	Dishwashers					16
17	Maintenance Workers	1,977	2,122	23,650	11.15	17
18	Housekeepers	6,022	6,875	71,896	10.46	18
19	Laundry	2,732	2,987	25,923	8.68	19
20	Administrator	1,810	2,104	45,136	21.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,264	1,746	25,525	14.62	23
24	Clerical	2,825	3,006	41,152	13.69	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)	85,155	92,919	\$ 1,126,165 *	\$ 12.12	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	98	\$ 5,213	1/3	35
36	Medical Director	Monthly	3,000	9/3	36
37	Medical Records Consultant	14	641	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	660	11/3	44
45	Social Service Consultant	12	660	12/3	45
46	Other(specify) <u>Bookkeeping</u>	275	4,125	21/3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	411	\$ 14,299		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	414	\$ 18,469	10/3	50
51	Licensed Practical Nurses	1,389	45,113	10/3	51
52	Certified Nurse Assistants/Aides	2,756	52,281	10/3	52
53	TOTAL (lines 50 - 52)	4,559	\$ 115,863		53





Facility Name &amp; 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? 5 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. N/A
- (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. \$ 35,105  
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? N/A Indicate the amount. \$
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? 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.

Facility Name & ID Number	Grange Nursing Home	#0014399	Report Period Beginning	1/1/2008	Ending	12/31/2008
XIX. Support Schedule for Page 21, G. Schedule of Travel and Seminar						
Person Attending	Title	Date	Location	Reason	Cost	
Cindi Reidelberger	Social Service	1/2/2008	Belleville, IL	Screen resident	23	
Carlton Hart	Maintenance	1/30/2008	St. Louis, MO	Pick up supplies	35	
Cindi Reidelberger	Social Service	1/30/2008	Belleville, IL	Screen residents	45	
Dolores McCullough	Office Manager	1/30/2008	Mt Vernon, IL	Seminar	58	
Cindi Reidelberger	Social Service	2/29/2008	Belleville & Fairview Heights, IL	Needs of residents	68	
Jennifer Wilkerson	LPN	3/20/2008	Belleville, IL	Pick up medication	22	
Cindi Reidelberger	Social Service	3/26/2008	East St. Louis, MO	Screen resident	35	
Cindi Reidelberger	Social Service	4/30/2000	Belleville, IL	Residents clothing	27	
Cindi Reidelberger	Social Service	4/30/2008	Belleville, IL	Public Aid office	27	
Janice Pheil	LPN	5/13/2008	Springfield, IL	Restorative Nurse class	191	
Lee Preis	Volunteer	5/13/2008	St. Louis, MO	Pick up tables	37	
Janice Pheil	LPN	5/23/2008	Springfield, IL	Restorative Nurse class	191	
Jennifer Preis	Activity director	5/28/2008	Breese, IL	Activity Director class	46	
Cindi Reidelberger	Social Service	5/30/2008	St. Louis, MO	Screen potential resident	60	
Janice Pheil	LPN	5/30/2008	Springfield, IL	Restorative Nurse class	286	
Janice Pheil	LPN	6/9/2008	Springfield, IL	Test for Restorative Nurse	131	
Susan Preis	Bookkeeper	6/13/2008	Belleville, IL	Pick up office equipment	15	
Dolores McCullough	Office Manager	6/17/2008	Mt. Vernon, IL	Inservice seminar	61	
Wenneman Market	Supplier	6/23/2008	St. Libory, IL	fuel surcharge	3	
Cindi Reidelberger	Social Service	6/24/2008	St. Louis, MO	Screen potential resident	46	
Living Design, Inc	Supplier	6/30/2008	St. Louis, MO	fuel surcharge	30	
Jennifer Wilkerson	LPN	7/10/2008	Belleville, IL	Nurse morale awards	13	
Cindi Reidelberger	Social Service	7/26/2008	Belleville, IL	Residents BBQ Lunch supplies	44	
Cindi Reidelberger	Social Service	8/29/2008	Belleville, IL	Residents clothing left at hospital	23	
John Stricker	Volunteer	8/29/2008	Okawville, IL	Pick up rock	23	
Cindi Reidelberger	Social Service	8/29/2008	Chesterfield, MO	Screen potential resident	46	
Carlton Hart	Maintenance	9/17/2008	St. Louis, MO	Pick up supplies	41	
Carlton Hart	Maintenance	9/30/2008	St. Louis, MO	Pick up supplies	51	
Jennifer Allard	ADON	10/9/2008	Belleville, IL	Pick up residents supplies	16	
Cindi Reidelberger	Social Service	10/14/2008	St. Louis, MO	Screen potential resident	55	
Joni Suemnicht	DON	11/17/2008	Belleville, IL	Pick up medical supplies	32	
Lynn Haas	Administrator	11/21/2008	Springfield, IL	Administrators review course	121	
Cindi Reidelberger	Social Service	12/5/2008	St. Louis, MO	Screen potential resident	57	
Carlton Hart	Maintenance	12/23/2008	St. Louis, MO	Pick up supplies	41	
		1/25/2008	Illinois Health Care Association	Class Medicaid audits	400	
		2/25/2008	Specialized Wound Management	Wound care class	69	
		5/6/2008	Pathway Health Services Inc	Seminar for training restorative nurse	729	
		10/30/2008	Illinois Health Care Association	Seminar for administrators	595	
Total to Page 21, Schedule G					3,792	