



Facility Name & ID Number Grange Nursing Home

# 0014399 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

**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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,075	7

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

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,735	6,318	993	14,046	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,735	6,318	993	14,046	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.97%

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  Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 993

Medicare Intermediary CGS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

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# 0014399

Report Period Beginning:

01/01/2011

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## 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	148,480	8,732	6,299	163,511		163,511		163,511		1
2	Food Purchase		96,483		96,483		96,483		96,483		2
3	Housekeeping	69,376	11,075		80,451		80,451		80,451		3
4	Laundry	33,183	3,985		37,168		37,168		37,168		4
5	Heat and Other Utilities			64,909	64,909		64,909		64,909		5
6	Maintenance	37,852	1,389	20,889	60,130		60,130		60,130		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	288,891	121,664	92,097	502,652		502,652		502,652		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	790,902	35,877	36,493	863,272		863,272		863,272		10
10a	Therapy			189,641	189,641		189,641		189,641		10a
11	Activities	35,035	1,913	656	37,604		37,604		37,604		11
12	Social Services	9,648		2,044	11,692		11,692		11,692		12
13	CNA Training										13
14	Program Transportation			3,486	3,486		3,486		3,486		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	835,585	37,790	235,320	1,108,695		1,108,695		1,108,695		16
	<b>C. General Administration</b>										
17	Administrative	73,406			73,406		73,406		73,406		17
18	Directors Fees										18
19	Professional Services			37,098	37,098		37,098	(9,973)	27,125		19
20	Dues, Fees, Subscriptions & Promotions			5,958	5,958		5,958		5,958		20
21	Clerical & General Office Expenses	88,940	12,656	9,867	111,463		111,463	(723)	110,740		21
22	Employee Benefits & Payroll Taxes			375,061	375,061		375,061		375,061		22
23	Inservice Training & Education			1,901	1,901		1,901		1,901		23
24	Travel and Seminar			1,433	1,433		1,433		1,433		24
25	Other Admin. Staff Transportation			2,252	2,252		2,252		2,252		25
26	Insurance-Prop.Liab.Malpractice			32,660	32,660		32,660		32,660		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	162,346	12,656	466,230	641,232		641,232	(10,696)	630,536		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,286,822	172,110	793,647	2,252,579		2,252,579	(10,696)	2,241,883		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.

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			34,989	34,989		34,989		34,989			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,834	11,834		11,834	(166)	11,668			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,254	4,254		4,254		4,254			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			51,077	51,077		51,077	(166)	50,911			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,730		97,730		97,730		97,730			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,469	54,469		54,469		54,469			42
43	Other (specify):* <b>Non-Allow Costs</b>			22,863	22,863		22,863	(22,863)				43
44	<b>TOTAL Special Cost Centers</b>		97,730	77,332	175,062		175,062	(22,863)	152,199			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,286,822	269,840	922,056	2,478,718		2,478,718	(33,725)	2,444,993			45

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

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**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	(166)	32		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	(5,614)	43		18
19	Entertainment	(1,499)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(26,446)	var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (33,725)		\$	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>	\$ (33,725)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income Offset	\$ (723)	21	1
2	Labs - Part A	(2,032)	43	2
3	X-Rays - Part A	(6,891)	43	3
4	Late Fees	(2,293)	43	4
5	Advertising	(4,505)	43	5
6	Decreased Resident Tribute	(29)	43	6
7	Nonallowable Legal	(9,973)	19	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>	(26,446)		49

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**VII. RELATED PARTIES**

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

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

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**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30



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## 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	N/A	\$ 0	N/A 1	
2	Richard Pyle	Treasurer	Board Member	None	None	<1	0.01	N/A	0	N/A 2	
3	Sophie Treser	Secretary	Board Member	None	None	<1	0.01	N/A	0	N/A 3	
4	Mildred Meinkoth	Director	Board Member	None	None	<1	0.01	N/A	0	N/A 4	
5	James Eckert	Director	Board Member	None	None	<1	0.01	N/A	0	N/A 5	
6	William Woods	Director	Board Member	None	None	<1	0.01	N/A	0	N/A 6	
7										7	
8	The Board Members do not provide direct service to the facility nor receive compensation										8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address N/A  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	<b>Working Capital</b>																	
6	Citizens Community Bank		X	Line Of Credit		8/31/2010	250,000	220,441	8/31/2012	Variable		11,834						
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$ 250,000	\$ 220,441				\$ 11,834						
	<b>B. Non-Facility Related*</b>																	
10							Disallow nonallowable interest expense					(166)						
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$ (166)						
15	<b>TOTALS (line 9+line14)</b>						\$ 250,000	\$ 220,441				\$ 11,668						

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

\* 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.)





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**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).

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: \_\_\_\_\_ 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Care Facility</u>	<u>30,000</u>	<u>1962</u>	<u>\$ 1,064</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>30,000</b>		<b>\$ 1,064</b>	<b>3</b>

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	29		1963	1963	\$ 125,662	\$ 2,513	50	\$ 2,513		\$ 122,034	4
5	26		1969	1969	148,564		40			148,564	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Sewer & water		1964		7,560	151	50	151		7,231	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	Insulation		1985		3,980		15			3,980	18
19	Sprinkler System		1985		2,187		20			2,187	19
20	Building Addition		1987		272,812	10,104	27	10,104		246,873	20
21	Skylights		1988		1,790		20			1,790	21
22	Windows		1988		1,138		20			1,138	22
23	Bathroom Remodeling		1989		10,065		20			10,065	23
24	Outside Aluminium Shed		1989		1,815		10			1,815	24
25	Chair Rails		1989		441		10			441	25
26	Install Shutoff Valves		1990		3,045		20			3,045	26
27	Door alarm & Air Conditioners		1990		2,425		10			2,425	27
28	Heat Pump & Awing		1993		4,577		10			4,577	28
29	Fence		1993		2,931	147	20	147		2,667	29
30	Sprinklers, Keypad to Patio Doors		1994		1,267	63	20	63		1,113	30
31	Sidewalks & Trees		1994		13,361	668	20	668		11,636	31
32	Activity Doors, Coder Alert, Door Alarm		1994		5,346		10			5,346	32
33	Awning, Exhaust Fans		1994		6,204		10			6,204	33
34	Courtyard		1996		7,310	246	15	246		7,310	34
35	Soiled Utility Room		1996		6,751	225	15	225		6,751	35
36	30% Downpayment on Fire Alarm System		1996		2,573	129	20	129		1,997	36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

\*\*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:

01/01/2011 Ending: 12/31/2011**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1997	\$ 6,226	\$ 311	20	\$ 311		\$ 4,512	37
38	1997	3,476		10			3,476	38
39	1997	4,618	185	25	185		2,680	39
40	1997	1,402	70	20	70		1,016	40
41	1997	2,112	141	15	141		2,043	41
42	1997	10,764	717	15	717		10,407	42
43	1997	2,800	140	20	140		2,030	43
44	1997	1,488	99	15	99		1,438	44
45	1998	10,151		10			10,151	45
46	1998	2,530		10			2,530	46
47	1998	402	21	19	21		295	47
48	1999	2,900	145	20	145		1,813	48
49	1999	2,628		10			2,628	49
50	2001	1,900		5			1,900	50
51	2001	26,134	1,307	10	1,307		26,134	51
52	2002	1,519	152	10	152		1,443	52
53	2002	4,674	467	10	467		4,440	53
54	2002	2,749	275	10	275		2,612	54
55	2002	14,902	1,491	10	1,491		14,157	55
56	2002	11,009	1,101	10	1,101		10,458	56
57	2002	2,160	216	10	216		2,052	57
58	2002	8,342	834	10	834		7,924	58
59	2003	23,086	2,309	10	2,309		19,624	59
60	2004	3,329	332	10	332		2,495	60
61	2004	8,326	555	15	555		4,163	61
62	2005	1,792	120	15	120		727	62
63	2005	2,904	194	15	194		1,275	63
64	2005	1,900	127	15	127		771	64
65	2005	2,400	240	10	240		1,460	65
66	2005	2,041	204	10	204		1,412	66
67	2007	5,800	387	15	387		1,644	67
68	2007	2,600	173	15	173		765	68
69	2010	2,691	179	15	179		343	69
70		\$ 914,690	\$ 26,738		\$ 26,738		\$ 851,137	70

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



**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Costs-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 70,679	\$ 8,251	\$ 8,251	\$		\$ 41,064	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	262,054					262,054	73
74								74
75	<b>TOTALS</b>	\$ 332,733	\$ 8,251	\$ 8,251	\$		\$ 303,118	75

**D. Vehicle Costs. (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77		N/A								77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)		\$ 1,248,487	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 34,989	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 34,989	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)		\$ 1,154,255	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93		N/A	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: 01/01/2011

Ending: 12/31/2011

**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

\*\*

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: \$ 4,254 Description: Dishwasher \$587; Copier \$1,218; Dietary Equip. \$657; Medical Equip. \$1,792

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2012 \$ \_\_\_\_\_

13. \_\_\_\_\_/2013 \$ \_\_\_\_\_

14. \_\_\_\_\_/2014 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	918	\$ 66,131			\$	918	\$ 66,131	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		455	32,743				455	32,743	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(3)	hrs		1,261	90,767				1,261	90,767	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					85,101			85,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Oxygen</u>	39(2)						12,629			12,629	12
13	Other (specify):											13
14	<b>TOTAL</b>			\$	2,634	\$ 189,641		\$ 97,730		2,634	\$ 287,371	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 &amp; ID Number Grange Nursing Home

# 0014399

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 160,707	\$ 160,707	1
2	Cash-Patient Deposits	393	393	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u> )	591,131	591,131	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,687	29,687	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	18,374	18,374	8
9	Other(specify):	15,289	15,289	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 815,581	\$ 815,581	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,064	1,064	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	914,690	914,690	15
16	Equipment, at Historical Cost	332,733	332,733	16
17	Accumulated Depreciation (book methods)	(1,154,255)	(1,154,255)	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>	\$ 94,232	\$ 94,232	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 909,813	\$ 909,813	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 512,471	\$ 512,471	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,943	50,943	30
31	Accrued Taxes Payable (excluding real estate taxes)			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>See Sch17A</u>	366,066	366,066	36
37	<u>Misc W/H and Accrued Payroll Taxes</u>	4,017	4,017	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 933,497	\$ 933,497	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	220,441	220,441	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Sale of Business</u>	80,000	80,000	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 300,441	\$ 300,441	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,233,938	\$ 1,233,938	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (324,125)	\$ (324,125)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 909,813	\$ 909,813	48

\*(See instructions.)

Grange Nursing Home  
1/1/11-12/31/11  
Provider # 0014399

Schedule 17A

XV. Balance Sheet  
C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due From Terrace on the Park	8,467	8,467
Due to/from Way-fair	357,599	357,599
	<u>366,066</u>	<u>366,066</u>
	-	-

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>110,819</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>110,819</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(434,944)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (434,944)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (324,125)	<b>24</b> *

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

**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	\$ 2,037,170	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,037,170	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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	115	24
25	Interest and Other Investment Income***	166	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 281	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Rent and Miscellaneous Income</u>	6,323	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,323	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,043,774	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	502,652	31
32	Health Care	1,108,695	32
33	General Administration	641,232	33
<b>B. Capital Expense</b>			
34	Ownership	51,077	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	120,593	35
36	Provider Participation Fee	54,469	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,478,718	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(434,944)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (434,944)	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:

01/01/2011

Ending:

12/31/2011

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	1,495	1,595	\$ 41,497	\$ 26.02	1
2	Assistant Director of Nursing	60	76	1,392	18.32	2
3	Registered Nurses	5,767	6,077	132,465	21.80	3
4	Licensed Practical Nurses	10,213	11,437	216,368	18.92	4
5	CNAs & Orderlies	32,960	35,819	391,857	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,581	3,055	35,035	11.47	10
11	Social Service Workers	455	599	9,648	16.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,210	13,157	148,480	11.29	15
16	Dishwashers					16
17	Maintenance Workers	2,404	2,588	37,852	14.63	17
18	Housekeepers	5,244	5,938	69,376	11.68	18
19	Laundry	2,833	3,299	33,183	10.06	19
20	Administrator	2,309	2,773	73,406	26.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,141	2,455	44,569	18.15	23
24	Clerical	2,260	2,926	44,371	15.16	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 MDS Coordinator	320	320	7,323	22.88	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,252	92,114	\$ 1,286,822 *	\$ 13.97	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	108	\$ 6,299	1(3)	35
36	Medical Director	Monthly	3,000	9(3)	36
37	Medical Records Consultant	9	391	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	4	418	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	656	11(3)	44
45	Social Service Consultant	36	2,044	12(2)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	169	\$ 12,808		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	16	\$ 728	10(3)	50
51	Licensed Practical Nurses	423	14,533	10(3)	51
52	Certified Nurse Assistants/Aides	997	20,423	10(3)	52
53	TOTAL (lines 50 - 52)	1,436	\$ 35,684		53



Grange Nursing Home  
1/1/11-12/31/11  
XIX. Support Schedules

Schedule 21C

C. Professional Fees

Total Schedule V, line 19, column 3 37,098

Nonallowable Legal (9,973)

Total Schedule V, line 19, column 8 27,125

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3								N/A				
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Grange Nursing Home# 0014399Report Period Beginning: 01/01/2011Ending: 12/31/2011**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 Yrs
- (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 N/A
- (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. \$ 54,469  
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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? 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? Adequate records have been maintained.  
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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees