FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0044271

Facility Name: Grasmere Place

Address: 4621 N. Sheridan Rd (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 334-6601 **Fax #** (773) 334-3619

HFS ID Number:

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	216	Intermediate (ICF)	216	78,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	78,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	72,254	212		72,466	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,254	212		72,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.92%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	230,489	47,190		277,679		277,679	10,933	288,612			1
2	Food Purchase		350,468		350,468		350,468	353	350,821			2
3	Housekeeping	266,420	55,195		321,615		321,615	(1,707)	319,908			3
4	Laundry		11,613	46,994	58,607		58,607	(55)	58,552			4
5	Heat and Other Utilities			153,634	153,634		153,634	1,583	155,217			5
6	Maintenance	148,588		233,046	381,634		381,634	(20,870)	360,764			6
7	Other (specify):*							3,605	3,605			7
8	TOTAL General Services	645,497	464,466	433,674	1,543,637		1,543,637	(6,158)	1,537,479			8
	B. Health Care and Programs											
9	Medical Director			8,600	8,600		8,600		8,600			9
10	Nursing and Medical Records	1,393,835	70,585	14,748	1,479,168		1,479,168	56,545	1,535,713			10
10a	Therapy											10a
11	Activities	359,036	31,561	14,912	405,509		405,509		405,509			11
12	Social Services	714,293	15,302	6,723	736,318		736,318	8,729	745,047			12
13	CNA Training											13
14	Program Transportation			1,475	1,475		1,475		1,475			14
15	Other (specify):*							11,846	11,846			15
16	TOTAL Health Care and Programs	2,467,164	117,448	46,458	2,631,070		2,631,070	77,120	2,708,190			16
	C. General Administration											
17	Administrative	119,069			119,069		119,069	69,043	188,112			17
18	Directors Fees											18
19	Professional Services			331,706	331,706		331,706	(225,801)	105,905			19
20	Dues, Fees, Subscriptions & Promotions			67,197	67,197		67,197	(13,967)	53,230			20
21	Clerical & General Office Expenses	170,108	21,833	105,321	297,262		297,262	139,256	436,518			21
22	Employee Benefits & Payroll Taxes			601,152	601,152		601,152	(7,961)	593,191			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,145	3,145		3,145	2,902	6,047			24
25	Other Admin. Staff Transportation			1,101	1,101		1,101	633	1,734			25
26	Insurance-Prop.Liab.Malpractice			181,479	181,479		181,479	30,283	211,762			26
27	Other (specify):*							39,562	39,562			27
28	TOTAL General Administration	289,177	21,833	1,291,101	1,602,111		1,602,111	33,951	1,636,062			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,401,838	603,747	1,771,233	5,776,818		5,776,818	104,912	5,881,730			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Grasmere Place #0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,395	51,395		51,395	224,810	276,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,016	1,016		1,016	470,408	471,424			32
33	Real Estate Taxes							199,118	199,118			33
34	Rent-Facility & Grounds			945,934	945,934		945,934	(943,391)	2,543			34
35	Rent-Equipment & Vehicles			10,896	10,896		10,896	(2,012)	8,884			35
36	Other (specify):*							43,304	43,304			36
37	**TOTAL Ownership**			1,009,241	1,009,241		1,009,241	(7,764)	1,001,477			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		880		880		880	(653)	227			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,644	58,644		58,644		58,644			42
43	Other (specify):*			60,000	60,000		60,000	(60,000)				43
44	**TOTAL Special Cost Centers**		880	118,644	119,524		119,524	(60,653)	58,871			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,401,838	604,627	2,899,118	6,905,583		6,905,583	36,496	6,942,079			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	6,529	30		9
10	Interest and Other Investment Income	(28,314)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	02		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	(1,331)	21		18
19	Entertainment				19
20	Contributions	(5,236)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,548)	21		24
25	Fund Raising, Advertising and Promotional	(764)	20		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	(139,229)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,903)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	223,399		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 223,399		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 36,496		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (120)	10	1
2	Theft Loss	(556)	21	2
3	Collection Expense	(2,448)	21	3
4	Annual Report	(250)	20	4
5	Additional R&M	5,447	06	5
6	Capitalized R&M	(50,223)	06	6
7	Non-Allowable Expense	(60,000)	43	7
8	Building Co. - Audit Fees	(7,500)	19	8
9	Building Co. - Filing Fees	(250)	21	9
10	Building Co. - Amortization	(2,260)	36	10
11	Non-Allowable Legal	(3,396)	19	11
12	ICLTC - COPE Dues	(5,484)	20	12
13	Alliance - PAC Dues	(12,189)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(139,229)		49

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Grasmere Place **#** 0044271 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			378		10,555							10,933	1
2	Food Purchase	(10)		363									353	2
3	Housekeeping			765		137		(2,609)					(1,707)	3
4	Laundry							(55)					(55)	4
5	Heat and Other Utilities			1,342		241							1,583	5
6	Maintenance	(44,776)	9,810	3,852	10,195	49							(20,870)	6
7	Other (specify):*				1,828	1,777							3,605	7
8	**TOTAL General Services**	(44,786)	9,810	6,700	12,023	12,759		(2,664)					(6,158)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(120)				58,895		(2,230)					56,545	10
10a	Therapy													10a
11	Activities													11
12	Social Services					8,729							8,729	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					11,383	463						11,846	15
16	**TOTAL Health Care and Programs**	(120)				79,007	463	(2,230)					77,120	16
	C. General Administration													
17	Administrative			4,024	13,702	51,317							69,043	17
18	Directors Fees													18
19	Professional Services	(10,896)	7,500	(184,777)		(37,628)							(225,801)	19
20	Fees, Subscriptions & Promotions	(18,687)		4,505		215							(13,967)	20
21	Clerical & General Office Expenses	(28,369)	250	16,688	140,071	10,616							139,256	21
22	Employee Benefits & Payroll Taxes				(7,459)		(463)	(39)					(7,961)	22
23	Inservice Training & Education													23
24	Travel and Seminar			249		2,653							2,902	24
25	Other Admin. Staff Transportation			633									633	25
26	Insurance-Prop.Liab.Malpractice		28,876	1,199		208							30,283	26
27	Other (specify):*				29,795	9,767							39,562	27
28	**TOTAL General Administration**	(57,951)	36,626	(157,479)	176,109	37,148	(463)	(39)					33,951	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,858)	46,436	(150,779)	188,132	128,914		(4,933)					104,912	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Grasmere Place** **#** **0044271** **Report Period Beginning:** **01/01/11** **Ending:** **12/31/11**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	6,529	203,342	12,954		1,985							224,810	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(28,314)	487,075	11,018		629							470,408	32
33	Real Estate Taxes		196,775	1,986		357							199,118	33
34	Rent-Facility & Grounds		(943,391)										(943,391)	34
35	Rent-Equipment & Vehicles			4,910					(6,922)				(2,012)	35
36	Other (specify):*	(2,260)	45,564										43,304	36
37	**TOTAL Ownership**	(24,045)	(10,635)	30,868		2,971			(6,922)				(7,764)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(20)	(633)				(653)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,000)											(60,000)	43
44	**TOTAL Special Cost Centers**	(60,000)						(20)	(633)				(60,653)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(186,903)	35,801	(119,911)	188,132	131,885		(4,953)	(7,555)				36,496	45

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
See Attached 6-Supplemental		See Attached 6-Supplemental		See Attached 6-Supplemental		

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 943,391	Grasmere Real Estate, LLC	100.00%	$	$ (943,391)	1
2	V	32	Interest	573	Grasmere Real Estate, LLC		487,648	487,075	2
3	V	19	Audit Fees		Grasmere Real Estate, LLC		7,500	7,500	3
4	V	21	Bank Charges		Grasmere Real Estate, LLC				4
5	V	36	MIP Expense		Grasmere Real Estate, LLC		43,304	43,304	5
6	V	33	Real Estate Taxes		Grasmere Real Estate, LLC		196,775	196,775	6
7	V	26	Insurance		Grasmere Real Estate, LLC		28,876	28,876	7
8	V	21	Filing Fees		Grasmere Real Estate, LLC		250	250	8
9	V	36	Amortization		Grasmere Real Estate, LLC		2,260	2,260	9
10	V	30	Depreciation		Grasmere Real Estate, LLC		203,342	203,342	10
11	V	06	Repairs & Maintenance		Grasmere Real Estate, LLC		9,810	9,810	11
12	V								12
13	V								13
14	Total			$ 943,964			$ 979,765	$ * 35,801	14

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 378	$ 378	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	363	363	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	765	765	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,342	1,342	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,852	3,852	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,024	4,024	20
21	V	19	Professional Fees	192,300	Extended Care Consulting, LLC	100.00%	7,523	(184,777)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	4,505	4,505	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	16,688	16,688	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	249	249	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	633	633	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,199	1,199	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	12,954	12,954	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	11,018	11,018	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,986	1,986	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	4,910	4,910	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 192,300			$ 72,389	$ * (119,911)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	10,195	$ 10,195	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,828	1,828	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	13,702	13,702	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	140,071	140,071	22
23	V	21	Office and Clerical (Direct)	22,124	Extended Care Consulting, LLC	100.00%	22,124		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	26,459	26,459	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,336	3,336	25
26	V	22	Employee Benefits	7,459	Extended Care Consulting, LLC	100.00%		(7,459)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 29,583			$ 217,715	$ * 188,132	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 137	$ 137	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	241	241	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	49	49	17
18	V	19	Professional Fees	64,104	Extended Care Clinical, LLC	100.00%	26,476	(37,628)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	215	215	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	3,913	3,913	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,653	2,653	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	208	208	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,985	1,985	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	629	629	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	357	357	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	10,555	10,555	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,777	1,777	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	58,895	58,895	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	8,729	8,729	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	11,383	11,383	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	51,317	51,317	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	6,703	6,703	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,767	9,767	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 64,104			$ 195,989	$ * 131,885	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing / Medical Record Salary	1,399	Extended Care Clinical, LLC	100.00%	1,399		17
18	V	12	Social Service / Admission Salary	2,883	Extended Care Clinical, LLC	100.00%	2,883		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	463	463	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	463	Extended Care Clinical, LLC	100.00%		(463)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,745			$ 4,745	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	43,041	Xcel Supply, LLC	100.00%	40,431	(2,609)	16
17	V	4	Laundry	907	Xcel Supply, LLC	100.00%	852	(55)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	36,782	Xcel Supply, LLC	100.00%	34,552	(2,230)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits	641	Xcel Supply, LLC	100.00%	602	(39)	22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	334	Xcel Supply, LLC	100.00%	314	(20)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 81,704			$ 76,751	$ * (4,953)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ventilator Equipment	880	Vent Lease LLC	100.00%	300	(580)	15
16	V	39	Other Ancillary	80	Vent Lease LLC	100.00%	27	(53)	16
17	V	35	Matrix Leasing	6,922	Vent Lease LLC	100.00%		(6,922)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,882			$ 327	$ * (7,555)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 193,195	$ 193,195	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	193,195	CCS Employee Benefits Group	100.00%		(193,195)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 193,195			$ 193,195	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	ADAM VALES	1.852%			GRASMERE REAL ESTATE, LLC		BUILDING CO.	1
2	ADAM VALES ACCUM. TRUST	4.861%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	DANIEL ROTHNER	1.852%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	DANIEL ROTHNER ACCUM TRUST	4.861%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	4
5	DR. DAVID & SARA ROTHNER	0.694%	BRIAR PLACE, LTD.	INDIAN HEAD	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	5
6	KATHRYN SILVERS	1.852%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	VENTLEASE,LLC	EVANSTON	VENTALATOR RENTAL	6
7	KATHRYN VALES ACCUM TRUST	4.861%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	7
8	KIMBERLY RICHMOND ACCUM. TRUST	4.861%	DYER NURSING & REHAB	DYER, IN				8
9	KIMBERLY RUDOLPH	1.852%	HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				9
10	LINDA VARDI	0.694%	HOMESTEAD NURSING & REAHB	LINCOLN, NE				10
11	MELISSA ROTHNER	1.852%	GOLDEN PLAINES	HUTCHINSON<KS				11
12	MELISSA ROTHNER ACCUM. TRUST	4.861%	LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				12
13	N. & S. ROTHNER FAMILY TRUST	46.991%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				13
14	NATHAN & SHIRLEY GRANDCHILDREN	3.241%	LANCASTER MANOR	LINCOLN, NE				14
15	NEAL & BEATA ROTHNER	0.694%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				15
16	RACHEL ROTHNER	1.852%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				16
17	RACHEL ROTHNER ACCUM TRUST	4.861%	OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				17
18	SANDRA & HILLEL KLIERS	0.694%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				18
19	WILLIAM ROTHNER	1.852%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				19
20	WILLIAM ROTHNER ACCUM. TRUST	4.861%	PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				20
21			RAINBOW BEACH QOC, L.L.C.	CHICAGO				21
22			SEBOS NURSING & REHAB	HOLBART, IN				22
23								23
24			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				24
25			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				25
26			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				26
27			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				27
28			WHEATON CARE CENTER	WHEATON				28
29								29
30								30

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	G. Matt Silvers	Relative	Administrative	0%	See Attached	0.26	0.65%	Alloc Salary	$ 1,025	17-7	1
2	Adam Vales	Shareholder	Clerical	1.85%	See Attached	1.42	3.55%	Alloc Salary	2,521	22-7	2
3	Mark Steinberg	Relative	Administrative	0%	See Attached	4.77	8.67%	Alloc Salary	15,621	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										11
12	the IL Dept of HFS.										12
13								TOTAL	$ 19,167		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 Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,332,501	31	$ 6,942	$	72,466	$ 378	1
2	02	Food	Patient Days	1,332,501	31	6,677		72,466	363	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		72,466	765	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		72,466	1,342	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		72,466	3,852	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		72,466	4,024	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		72,466	7,523	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		72,466	4,505	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		72,466	16,688	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		72,466	249	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		72,466	633	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		72,466	1,199	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		72,466	12,954	13
14	32	Interest	Patient Days	1,332,501	31	202,602		72,466	11,018	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		72,466	1,986	15
16	34	Rent - Building	Patient Days	1,332,501	31			72,466		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		72,466	4,910	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 72,389	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,332,501	31	187,474	187,474	72,466	10,195	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		72,466	1,828	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441				4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	72,466	13,702	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	72,466	140,071	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		22,124	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		72,466	26,459	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			3,336	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					$ 4,298,198	$ 3,682,723		$ 217,715	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	817,528	19	$ 1,549	$	72,466	$ 137	1
2	05	Utilities	Patient Days	817,528	19	2,718		72,466	241	2
3	06	Maintenance	Patient Days	817,528	19	557		72,466	49	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		72,466	26,476	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		72,466	215	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		72,466	3,913	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		72,466	2,653	7
8	26	Insurance	Patient Days	817,528	19	2,346		72,466	208	8
9	30	Depreciation	Patient Days	817,528	19	22,389		72,466	1,985	9
10	32	Interest	Patient Days	817,528	19	7,100		72,466	629	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		72,466	357	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	72,466	10,555	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		72,466	1,777	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	72,466	58,895	14
15	10a	Rehab Salary	Patient Days	817,528	19			72,466		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	72,466	8,729	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		72,466	11,383	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	72,466	51,317	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	72,466	6,703	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		72,466	9,767	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 195,989	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		1,399	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		2,883	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			463	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 4,745	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						40,431	2
3	4	Laundry	Direct Allocation						852	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						34,552	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation						602	8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						314	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					$	$		$ 76,751	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ventilator Equipment	Direct Allocation						300	1
2	39	Other Ancillary	Direct Allocation						27	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					$	$		$ 327	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 193,195	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					$	$		$ 193,195	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage	$71,078.00	1/26/99	$ 9,518,795	$ 8,598,585			$ 487,648	1
2	GMAC		X	Auto Loan							798	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Allocated from EC Consulting		X								11,018	6
7	Allocated from EC Clinical		X								629	7
8	See Supplemental Schedule							134,059			217	8
9	TOTAL Facility Related				$71,078.00		$ 9,518,795	$ 8,732,644			$ 500,310	9
	B. Non-Facility Related*											
10	Interest Income		X								(28,314)	10
11	Interest Income - Bldg. Co		X								(573)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (28,887)	14
15	TOTALS (line 9+line14)						$ 9,518,795	$ 8,732,644			$ 471,422	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 43,304 **Line #** 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Daiwa		X	Line of Credit			$	$ 134,059			$ 217	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							134,059			217	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 165,400	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.)		$ 179,018	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,618	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 185,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 199,118	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	199,970	8
	2007	199,245	9
	2008	201,657	10
	2009	157,553	11
	2010	176,675	12

2011 Accrual = $176,675 x 1.05 = $185,500

Allocated from Extended Care Consulting - $1,986

Allocated from Extended Care Clinical - $357

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-214-001-0000	Long Term Care Property	$ 157,144.45	$ 157,144.45
2.	14-17-214-002-0000	Long Term Care Property	$ 9,771.17	$ 9,771.17
3.	14-17-214-003-0000	Long Term Care Property	$ 9,759.63	$ 9,759.63
4.	See Attached	Allocation from 2201 Main	$ 126,481.18	$ 3,271.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 303,156.43	$ 179,946.25

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? X YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 800,000	1
2	Allocated from EC Consulting/Clinical 2201 Main			21,206	2
3	TOTALS			$ 821,206	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	216		1999	1964	$ 5,578,000	$	35	$ 159,371	$ 159,371	$ 2,058,142	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	83,114		20	3,790	3,790	46,488	9
10	Various			2000	251,874		20	12,463	12,463	148,213	10
11	Various			2001	59,759		20	2,988	2,988	31,797	11
12	Various			2002	147,991		20	13,094	13,094	131,951	12
13	Various			2003	29,651		20	1,483	1,483	12,919	13
14	Various			2004	70,279		20	6,799	6,799	53,869	14
15	Various			2005	42,283		20	4,228	4,228	26,773	15
16	Various			2006	25,997		20	2,600	2,600	14,236	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		758,963	203,342		37,950	(165,392)	346,923	67
68	Related Party Allocations (Pages 12H & 12I)		85,878	5,838		5,838		46,566	68
69	Financial Statement Depreciation			51,395			(51,395)		69
70	TOTAL (lines 4 thru 69)		$ 7,133,789	$ 260,575		$ 250,604	$ (9,971)	$ 2,917,875	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,133,789	$ 260,575		$ 250,604	$ (9,971)	$ 2,917,875	1
2	Electrical Work	2008	3,000		20	300	300	950	2
3	Repaired Riser & Sewer	2008	10,572		20	1,057	1,057	3,260	3
4	Glass Doors	2009	2,850		20	285	285	641	4
5	New Water Line	2009	14,934		20	1,493	1,493	3,485	5
6	New Masterkey System	2009	6,924		20	692	692	1,500	6
7	Carpeting	2010	2,584		20	369	369	584	7
8	Boiler Repairs	2011	6,882		20	688	688	688	8
9	Smoking Room Ventilation	2011	3,000		20	600	600	600	9
10	Carpeting	2011	9,470		20	1,240	1,240	1,240	10
11	Elevator Door Lock Work	2011	9,479		20	395	395	395	11
12	Masonry Work	2011	25,880		20	1,078	1,078	1,078	12
13	Alley & Sidewalk Canopy	2011	6,950		20	261	261	261	13
14	Replace Tub, Vent, Shower Valve, Pipes, Repair Walls, Install Tile	2011	3,740		20	94	94	94	14
15	Roof Repairs	2011	4,000		20	50	50	50	15
16	Replaced Broken Jockey Pump	2011	2,771		20	139	139	139	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	TOTAL (lines 1 thru 33)		$ 7,246,824	$ 260,575		$ 259,346	$ (1,229)	$ 2,932,840	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,246,824	$ 260,575		$ 259,346	$ (1,229)	$ 2,932,840	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,246,824	$ 260,575		$ 259,346	$ (1,229)	$ 2,932,840	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,246,824	$ 260,575		$ 259,346	$ (1,229)	$ 2,932,840	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,246,824	$ 260,575		$ 259,346	$ (1,229)	$ 2,932,840	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,246,824	$ 260,575		$ 259,346	$ (1,229)	$ 2,932,840	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
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16									16
17									17
18									18
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,246,824	$ 260,575		$ 259,346	$ (1,229)	$ 2,932,840	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Grasmere Real Estate	1999	301,871		20	15,094	15,094	208,258	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	48,638	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	9,500	11
12	Grasmere Real Estate (various)	2005	103,707		20	5,185	5,185	36,201	12
13	Exhaust Fan	2006	7,075		20	354	354	2,124	13
14	Vacuum Pump	2006	1,393		20	70	70	419	14
15	Window	2006	563		20	28	28	168	15
16	Gate	2006	5,700		20	285	285	1,710	16
17	Water Heater	2006	7,500		20	375	375	2,250	17
18	Elevator	2006	5,416		20	271	271	1,626	18
19	Boiler	2006	2,800		20	140	140	840	19
20	Plumbing	2006	45,784		20	2,289	2,289	12,642	20
21	Floor tiles	2006	1,045		20	52	52	313	21
22	Wall Paint	2006	532		20	27	27	161	22
23	Fire Alram	2006	1,100		20	55	55	330	23
24	Metal Hinges-Panels	2006	643		20	32	32	192	24
25	Cubicle Curtains	2007	3,559		20	178	178	890	25
26	Piping	2007	15,832		20	792	792	3,960	26
27	Fire Doors	2007	2,978		20	149	149	745	27
28	Piping Repair	2008	7,309		20	365	365	1,460	28
29	Elevator Repair	2008	2,738		20	137	137	548	29
30	Boiler Repair	2008	9,826		20	491	491	1,964	30
31	Carpet	2009	11,000		20	550	550	1,650	31
32	Fire Escape Repairs	2009	9,160		20	458	458	1,374	32
33	Masonry Repairs	2009	2,810		20	141	141	423	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2	USA Satellite & Cable	2009	9,620		20	481	481	1,443	2
3	Window Screen	2009	5,880		20	294	294	882	3
4	Boiler	2009	6,061		20	303	303	909	4
5	New Exterior Lights	2009	1,140		20	57	57	171	5
6	Masonry Repairs	2010	51,315		20	2,566	2,566	5,132	6
7	Grasmere Real Estate Book Depreciation			203,342			(203,342)		7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 758,963	$ 203,342		$ 37,950	$ (165,392)	$ 346,923	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main	2002	24,775	635	39	635		5,903	3
4	Allocated from Extended Care Clinical 2201 Main	2002	4,449	114	39	114		1,060	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	250	13	20	13		63	9
10	Allocated from Extended Care Consulting	2009	150	7	20	7		23	10
11	Allocated from Extended Care Consulting	2010	1,467	74	20	74		147	11
12	Allocated from Extended Care Consulting	2011	528	26	20	26		26	12
13									13
14	Allocated from Extended Care Consulting 2201 Main	2002	20,466	1,870	20	1,870		14,981	14
15	Allocated from Extended Care Consulting 2201 Main	2003	24,119	2,204	20	2,204		17,655	15
16	Allocated from Extended Care Consulting 2201 Main	2005	1,198	127	20	127		687	16
17	Allocated from Extended Care Consulting 2201 Main	2009	216	11	20	11		32	17
18									18
19	Allocated from Extended Care Clinical 2201 Main	2002	3,675	336	20	336		2,690	19
20	Allocated from Extended Care Clinical 2201 Main	2003	4,331	396	20	396		3,170	20
21	Allocated from Extended Care Clinical 2201 Main	2005	215	23	20	23		123	21
22	Allocated from Extended Care Clinical 2201 Main	2009	39	2	20	2		6	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 85,878	$ 5,838		$ 5,838	$	$ 46,566	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 103,195	$ 1,353	$ 5,741	$ 4,388	10	$ 91,832	71
72	Current Year Purchases	62,136	6,483	6,977	494	10	52,910	72
73	Fully Depreciated Assets	215,104				10	215,104	73
74								74
75	TOTALS	$ 380,436	$ 7,836	$ 12,718	$ 4,882		$ 359,846	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		2007 PONTIAC VIBE - AUTO	2007	$ 17,535	$	$ 2,877	$ 2,877	5	$ 15,018	76
77		Alloc. Extended Care Consult.	2011	17,488	273	273		5	17,214	77
78		Alloc. Extended Care Clinical	2011	4,955	991	991		5	3,303	78
79										79
80	TOTALS			$ 39,978	$ 1,264	$ 4,141	$ 2,877		$ 35,535	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)	$ 8,488,444	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 269,675	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 276,204	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,529	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,328,221	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	ESCORT - 2001	$ 8,270	$	$	86
87	VOLKSWAGEN NEW BEETLE - 2002	11,329			87
88					88
89					89
90					90
91	TOTALS	$ 19,599	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage Rental				2,543			5
6								6
7	TOTAL				$ 2,543 **			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: ____ *

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	$

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: $ 8,884 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2		3	4	5	6	7	8	
	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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						880		880	13
14	TOTAL			$		$	$ 880		$ 880	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 41,250	$ 235,644	1
2	Cash-Patient Deposits	81,850	81,850	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	732,820	732,820	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	274,427	274,427	6
7	Other Prepaid Expenses	5,494	30,521	7
8	Accounts Receivable (owners or related parties)	8,400	8,400	8
9	Other(specify): See Attached Schedule	29,808	623,677	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,174,049	$ 1,987,339	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	758,487	1,583,881	15
16	Equipment, at Historical Cost	232,707	1,836,030	16
17	Accumulated Depreciation (book methods)	(845,505)	(4,759,263)	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): See Attached Schedule		800,696	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 145,689	$ 5,839,344	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,319,738	$ 7,826,683	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 615,099	$ 615,099	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,026	27,026	28
29	Short-Term Notes Payable	134,059	134,059	29
30	Accrued Salaries Payable	181,757	181,757	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,085	4,085	31
32	Accrued Real Estate Taxes(Sch.IX-B)		185,500	32
33	Accrued Interest Payable		40,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	46,884	46,884	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,008,910	$ 1,234,752	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,598,585	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,598,585	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,008,910	$ 9,833,337	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 310,828	$ (2,006,654)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,319,738	$ 7,826,683	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Grasmere Place **#** 0044271 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (450,178)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (450,178)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	761,006	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)**	$ 761,006	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 310,828	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,638,288	1
2	Discounts and Allowances for all Levels	(19,126)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,619,162	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,947	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,947	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	17,174	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(128)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 17,046	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,314	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,314	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	120	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 120	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,666,589	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,543,637	31
32	Health Care	2,631,070	32
33	General Administration	1,602,111	33
	B. Capital Expense		
34	Ownership	1,009,241	34
	C. Ancillary Expense		
35	Special Cost Centers	60,880	35
36	Provider Participation Fee	58,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,905,583	40
41	**Income before Income Taxes (line 30 minus line 40)****	761,006	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 761,006	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **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.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,938	2,073	$ 83,730	$ 40.39	1
2	Assistant Director of Nursing	1,872	2,140	68,722	32.11	2
3	Registered Nurses	2,053	2,260	74,304	32.88	3
4	Licensed Practical Nurses	17,905	19,703	458,920	23.29	4
5	CNAs & Orderlies	60,327	67,028	686,234	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,877	2,121	48,626	22.93	9
10	Activity Assistants	8,926	9,876	98,810	10.01	10
11	Social Service Workers	37,345	41,704	714,293	17.13	11
12	Dietician	1,705	1,935	29,450	15.22	12
13	Food Service Supervisor	2,176	2,492	38,831	15.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,402	6,037	70,277	11.64	15
16	Dishwashers	9,174	10,246	91,931	8.97	16
17	Maintenance Workers	7,421	8,389	148,588	17.71	17
18	Housekeepers	23,621	26,305	266,420	10.13	18
19	Laundry					19
20	Administrator	1,861	2,148	119,069	55.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,981	10,385	170,108	16.38	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	1,870	2,062	21,925	10.63	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	29,379	36,672	211,600	5.77	33
34	TOTAL (lines 1 - 33)	223,833	253,576	$ 3,401,838 *	$ 13.42	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	8,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,349	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	24	3,840	12-03	45
46	Other(specify)				46
47	See Attached		4,282		47
48	Art Therapist	298	14,912	11-03	48
49	TOTAL (lines 35 - 48)	322	$ 44,983		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Celeste Jensen	Administrator	0	$ 119,069
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,069

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 23,900
Personnel Planners	Unemployment Tax Consult	1,218
See Attached	Legal	3,203
Extended Care Consulting	Home Office Expense	192,300
Extended Care Clinical	Home Office Expense	64,104
Paycor	Payroll Processing	15,143
Extended Care - Ability Network	Medicare Billing	1,538
National Datacare Corp.	Data Processing	2,967
National Hotline Services	Employee Compliance	167
Pinnacle Consulting	Customer Satisfaction	574
Prospect Resources	Natural Gas Procurement	1,400
See Supplemetal Schedule		25,193
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 331,706

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,934
Unemployment Compensation Insurance	44,688
FICA Taxes	243,693
Employee Health Insurance	180,421
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
City Payroll Tax	2,524
Employee Physicals	781
Pension Expense	22,068
Other Employee Welfare	2,904
Holiday Expense	4,178
TOTAL (agree to Schedule V, line 22, col.8)	$ 593,192

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 912
Advertising: Employee Recruitment	436
Health Care Worker Background Check	
(Indicate # of checks performed 277)	5,711
Patient Background Checks	
Dues & Subscriptions	38,476
Licenses & Fees	2,975
Allocated from EC Consulting	4,505
Allocated from EC Clinical	215
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,230

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,146
Allocated from EC Consulting	249
Allocated from EC Clinical	2,653
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,048

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/11 Ending: 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $21,546, Alliance for Living $33,048**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **255** Line **10**

(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. $ **58,644**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **N/A**

(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. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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.