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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 2/1/1999

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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	66,081	365		66,446	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,081	365		66,446	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.28%

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 02/01/1999

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/1999 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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Grasmere Place # 0044271 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	248,113	38,156		286,269		286,269	220	286,489			1
2	Food Purchase		345,555		345,555		345,555	567	346,122			2
3	Housekeeping	276,629	51,581		328,210		328,210	1,545	329,755			3
4	Laundry		17,293	63,487	80,780		80,780		80,780			4
5	Heat and Other Utilities			167,733	167,733		167,733	2,341	170,074			5
6	Maintenance	159,691		145,635	305,326		305,326	12,040	317,366			6
7	Other (specify):*							1,197	1,197			7
8	**TOTAL General Services**	684,433	452,585	376,855	1,513,873		1,513,873	17,910	1,531,783			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,408,222	57,975	21,947	1,488,144		1,488,144	(331)	1,487,813			10
10a	Therapy											10a
11	Activities	242,522	37,720	2,925	283,167		283,167		283,167			11
12	Social Services	742,682	14,797	5,680	763,159		763,159		763,159			12
13	CNA Training											13
14	Program Transportation			289	289		289		289			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,393,426	110,492	34,441	2,538,359		2,538,359	(331)	2,538,028			16
	C. General Administration											
17	Administrative	124,855			124,855		124,855	27,759	152,614			17
18	Directors Fees											18
19	Professional Services			404,907	404,907	(9,041)	395,866	(324,320)	71,546			19
20	Dues, Fees, Subscriptions & Promotions			68,804	68,804		68,804	(35,849)	32,955			20
21	Clerical & General Office Expenses	187,578	19,023	148,345	354,946		354,946	82,346	437,292			21
22	Employee Benefits & Payroll Taxes			608,715	608,715		608,715	(7,394)	601,321			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,965	1,965		1,965	474	2,439			24
25	Other Admin. Staff Transportation			1,455	1,455		1,455	1,887	3,342			25
26	Insurance-Prop.Liab.Malpractice			209,814	209,814		209,814	21,011	230,825			26
27	Other (specify):*							32,354	32,354			27
28	**TOTAL General Administration**	312,433	19,023	1,444,005	1,775,461	(9,041)	1,766,420	(201,732)	1,564,688			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,390,292	582,100	1,855,301	5,827,693	(9,041)	5,818,652	(184,153)	5,634,499			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Grasmere Place #0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			45,788	45,788		45,788	243,653	289,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							353,828	353,828			32
33	Real Estate Taxes					9,041	9,041	241,946	250,987			33
34	Rent-Facility & Grounds			1,035,698	1,035,698		1,035,698	(1,032,000)	3,698			34
35	Rent-Equipment & Vehicles			4,615	4,615		4,615	1,126	5,741			35
36	Other (specify):*							44,323	44,323			36
37	**TOTAL Ownership**			1,086,101	1,086,101	9,041	1,095,142	(147,124)	948,018			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			960	960		960	(10)	950			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			960	960		960	(10)	950			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,390,292	582,100	2,942,362	6,914,754		6,914,754	(331,286)	6,583,468			45

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	33,433	30		9
10	Interest and Other Investment Income	(533)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(19)	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				18
19	Entertainment				19
20	Contributions	(20,931)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,247)	21		24
25	Fund Raising, Advertising and Promotional	(2,823)	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	(63,879)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (127,999)		$	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)	(203,287)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (203,287)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (331,286)		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

STATE OF ILLINOIS **Page 5A**

Grasmere Place

ID# **0044271**

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty	$ (84)	10	1
2	Theft Loss	(235)	21	2
3	Collection Expense	(2,448)	21	3
4	Building Company - Management Fee	(10,050)	21	4
5	Building Company - Audit Fee	(11,300)	19	5
6	Building Company - Filing Fees	(250)	20	6
7	Building Company - Amortization Expense	(2,990)	31	7
8	Real Estate Tax Convenience Fee	(36)	33	8
9	Capitalized R&M	(8,125)	06	9
10	Alliance for Living - Political Dues	(13,225)	20	10
11	Annual Report	(250)	20	11
12	Non-allowable Legal	(14,886)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(63,879)		49

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grasmere Place # 0044271 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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			220									220	1
2	Food Purchase	(19)		586									567	2
3	Housekeeping			1,545									1,545	3
4	Laundry													4
5	Heat and Other Utilities			2,341									2,341	5
6	Maintenance	(8,125)		6,736	13,429								12,040	6
7	Other (specify):*				1,197								1,197	7
8	**TOTAL General Services**	(8,144)		11,428	14,626								17,910	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(84)					(246)						(331)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(84)					(246)						(331)	16
	C. General Administration													
17	Administrative			4,209	23,550								27,759	17
18	Directors Fees													18
19	Professional Services	(26,186)	11,300	(309,434)									(324,320)	19
20	Fees, Subscriptions & Promotions	(37,479)	250	1,380									(35,849)	20
21	Clerical & General Office Expenses	(85,980)	10,050	17,229	141,047								82,346	21
22	Employee Benefits & Payroll Taxes				(7,394)								(7,394)	22
23	Inservice Training & Education													23
24	Travel and Seminar			474									474	24
25	Other Admin. Staff Transportation			1,887									1,887	25
26	Insurance-Prop.Liab.Malpractice		19,085	1,926									21,011	26
27	Other (specify):*				32,354								32,354	27
28	**TOTAL General Administration**	(149,645)	40,685	(282,329)	189,557								(201,732)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(157,873)	40,685	(270,901)	204,183		(246)						(184,153)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Grasmere Place** **#** **0044271** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**33,433**	**207,168**	**3,052**									**243,653**	**30**
31	Amortization of Pre-Op. & Org.	**(2,990)**	**2,990**											**31**
32	Interest	**(533)**	**342,086**	**12,275**									**353,828**	**32**
33	Real Estate Taxes	**(36)**	**235,830**	**6,152**									**241,946**	**33**
34	Rent-Facility & Grounds		**(1,032,000)**										**(1,032,000)**	**34**
35	Rent-Equipment & Vehicles			**1,126**									**1,126**	**35**
36	Other (specify):*		**44,323**										**44,323**	**36**
37	**TOTAL Ownership**	**29,874**	**(199,603)**	**22,605**									**(147,124)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers						**(10)**						**(10)**	**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*													**43**
44	**TOTAL Special Cost Centers**						**(10)**						**(10)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(127,999)**	**(158,918)**	**(248,296)**	**204,183**		**(256)**						**(331,286)**	**45**

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 6-Supplemental		See 6-Supplemental		See 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	Rental Income	$ 1,032,000	Grasmere Real Estate, LLC	100.00%	$	$ (1,032,000)	1
2	V	32	Interest Income	408	Grasmere Real Estate, LLC	100.00%		(408)	2
3	V	21	Management Fee		Grasmere Real Estate, LLC	100.00%	10,050	10,050	3
4	V	19	Audit Fee		Grasmere Real Estate, LLC	100.00%	11,300	11,300	4
5	V	20	Filing Fees		Grasmere Real Estate, LLC	100.00%	250	250	5
6	V	30	Depreciation Expense		Grasmere Real Estate, LLC	100.00%	207,168	207,168	6
7	V	31	Amortization Expense		Grasmere Real Estate, LLC	100.00%	2,990	2,990	7
8	V	33	Real Estate Tax Expense		Grasmere Real Estate, LLC	100.00%	235,830	235,830	8
9	V	26	Insurance		Grasmere Real Estate, LLC	100.00%	19,085	19,085	9
10	V	32	Interest Expense - HUD		Grasmere Real Estate, LLC	100.00%	342,494	342,494	10
11	V	36	Mortgage Insurance		Grasmere Real Estate, LLC	100.00%	44,323	44,323	11
12	V								12
13	V								13
14	Total			$ 1,032,408			$ 873,490	$ * (158,918)	14

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 220	$ 220	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	586	586	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,545	1,545	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	2,341	2,341	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	6,736	6,736	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,209	4,209	20
21	V	19	Professional Fees	316,872	Extended Care Consulting, LLC	100.00%	7,438	(309,434)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,380	1,380	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	17,229	17,229	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	474	474	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,887	1,887	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,926	1,926	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,052	3,052	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	12,275	12,275	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	6,152	6,152	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,126	1,126	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			$ 316,872			$ 68,576	$ * (248,296)	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	13,429	$ 13,429	15
16	V	06	Maintenance (Direct)	489	Extended Care Consulting, LLC	100.00%	489		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,156	1,156	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	41	41	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	23,550	23,550	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	141,047	141,047	22
23	V	21	Office and Clerical (Direct)	24,156	Extended Care Consulting, LLC	100.00%	24,156		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	28,256	28,256	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,098	4,098	25
26	V	22	Employee Benefits	7,394	Extended Care Consulting, LLC	100.00%		(7,394)	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			$ 32,039			$ 236,222	$ * 204,183	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Various Equipment	960	Vent Lease LLC	100.00%	960	$	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			$ 960			$ 960	$ *	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 18,651	MAC Rx, LLC	100.00%	$ 18,405	$ (246)	15
16	V	39	Ancillary	727	MAC Rx, LLC	100.00%	717	(10)	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			$ 19,378			$ 19,122	$ * (256)	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$			$	$	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.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$			$	$	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.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$			$	$	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.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	WILLIAM ROTHNER ACCUM. TRUST	4.86%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	GRASMERE REAL ESTATE, LLC		BUILDING CO.	1
2	DANIEL ROTHNER ACCUM TRUST	4.86%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	RACHEL ROTHNER ACCUM TRUST	4.86%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	MELISSA ROTHNER ACCUM TRUST	4.86%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING CO.	4
5	ADAM VALES ACCUM TRUST	4.86%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQIP	5
6	KATHRYN VALES ACCUM TRUST	4.86%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	TRI CARE REHAB	HILLSIDE	THERAPY	6
7	KIMBERLY VALES ACCUM TRUST	4.86%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	7
8	NEAL & BEATA ROTHNER	.69%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	8
9	DR. DAVID & SARA ROTHNER	.69%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10	LINDA VARDI	.69%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11	SANDRA & HILLEL KLIERS	.69%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12	NATHAN & SHIRLEY GRANDCHILDREN TRUST	3.24%	MAJOR HOSPITAL SEBOS	HOBART, IN				12
13	WILLIAM ROTHNER	1.85%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14	DANIEL ROTHNER	1.85%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15	RACHEL ROTHNER	1.85%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16	MELISSA ROTHNER	1.85%	PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17	ADAM VALES	1.85%	RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18	KATHRYN SILVERS	1.85%	SHEFFIELD MANOR	DYER, IN				18
19	KIMBERLY RUDOLPH	1.85%	SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20	N. & S. ROTHNER FAMILY TRUST	4.69%	SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	Mark Steinberg	Relative	Administrative		See Attached	3.83	6.96%	Alloc Sal/Fee	$ 14,165	17-7	1
2											2
3											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 the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 14,165		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: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	66,446	$ 220	1
2	02	Food	Patient Days	1,326,152	31	11,689		66,446	586	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		66,446	1,545	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		66,446	2,341	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		66,446	6,736	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		66,446	4,209	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		66,446	7,438	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		66,446	1,380	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		66,446	17,229	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		66,446	474	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		66,446	1,887	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		66,446	1,926	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		66,446	3,052	13
14	32	Interest	Patient Days	1,326,152	31	244,990		66,446	12,275	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		66,446	6,152	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		66,446	1,126	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 68,576	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	66,446	13,429	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		489	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		66,446	1,156	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			41	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	66,446	23,550	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	66,446	141,047	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		24,156	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		66,446	28,256	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			4,098	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					$ 4,964,932	$ 4,280,758		$ 236,222	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 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	Various Equipment	Direct Allocation						960	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					$	$		$ 960	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 18,405	1
2	39	Ancillary	Direct Allocation						717	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					$	$		$ 19,122	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1/26/1999	$ 9,518,795	$ 7,963,598			$ 342,494	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Alloc - Ext. Care Consulting		X								12,275	6
7												7
8												8
9	TOTAL Facility Related				$71,078.00		$ 9,518,795	$ 7,963,598			$ 354,769	9
	B. Non-Facility Related*											
10	Interest Income		X								(533)	10
11	Interest Income - Bldg. Co.		X								(408)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (941)	14
15	TOTALS (line 9+line14)						$ 9,518,795	$ 7,963,598			$ 353,828	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 44,323 **Line #** 36

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

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 214,400	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.)		$ 213,346	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,054)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 243,000	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.**		$ 9,041	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.		$ 250,987	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	176,675	8
	2011	175,849	9
	2012	201,873	10
	2013	204,166	11
	2014	207,194	12

2015 Accrual is based on attached letter reflecting estimated future tax.
Allocated - Extended Care Consulting = $6,152

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 185,064.54	$ 185,064.54
2.	14-17-214-002-0000	Long Term Care Property	$ 11,070.15	$ 11,070.15
3.	14-17-214-003-0000	Long Term Care Property	$ 11,059.73	$ 11,059.73
4.	See Attached	Allocation from 2201 W. Main	$ 165,913.23	$ 5,817.64
5.	See Attached	Allocated from 502 Main Street	$ 3,814.66	$ 191.13
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 376,922.31	$ 213,203.19

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 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 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: 01/01/15 Ending: 12/31/15

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 2201 W. Main, LLC			28,753	2
3	TOTALS			$ 828,753	3

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 207,168	35	$ 159,371	$ (47,797)	$ 2,695,626	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	83,114		20	3,790	3,790	61,650	9
10	Various			2000	251,874		20	12,463	12,463	198,065	10
11	Various			2001	59,759		20	2,988	2,988	43,749	11
12	Various			2002	147,991		20	895	895	142,891	12
13	Various			2003	29,651		20	1,483	1,483	18,849	13
14	Various			2004	70,279		20	170	170	68,789	14
15	Various			2005	42,283		20	2,825	2,825	42,283	15
16	Various			2006	25,997		20	2,600	2,600	24,635	16
17	Various			2008	13,572		20	1,357	1,357	9,639	17
18	Various			2009	24,708		20	2,471	2,471	15,509	18
19	Various			2010	2,584		20	369	369	2,061	19
20	Various			2011	72,172		20	5,756	5,756	27,487	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: 01/01/15 Ending: 12/31/15

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)		977,528			48,921	48,921	531,246	67
68	Related Party Allocations (Pages 12H & 12I)		121,539	1,655		1,655		88,125	68
69	Financial Statement Depreciation			45,788			(45,788)		69
70	TOTAL (lines 4 thru 69)		$ 7,501,050	$ 254,611		$ 247,114	$ (7,496)	$ 3,970,604	70

**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: 01/01/15 Ending: 12/31/15

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		$ 7,501,050	$ 254,611		$ 247,114	$ (7,496)	$ 3,970,604	1
2	Formica Cubicles-North & South Halls-1St, 2Nd, 3Rd Floors	2012	18,900		20	1,890	1,890	7,560	2
3	Doors:Kitchen-Patio;Kitchen-Dining Rm; Masonry Repairs-Garb	2012	7,865		20	787	787	2,753	3
4	Curtains - Various Patient Rooms	2012	3,421		20	684	684	2,451	4
5	Dining Rm, Day Rm, Activity Rm, Lobby, Corridors - Vinyl Floor	2012	79,418		20	15,884	15,884	54,269	5
6	Concrete - Outdoor	2012	6,100		20	407	407	1,322	6
7	Dining Room Flooring	2012	9,013		20	901	901	2,854	7
8	Replaced 3 Vent Pipes On Water Heater	2012	4,483		20	224	224	897	8
9	Sewer Repairs	2012	3,392		20	170	170	594	9
10	Boiler Repairs	2012	4,890		20	489	489	1,549	10
11	Elevator - Replace Gate Switch And Sos Switch	2012	3,632		20	182	182	620	11
12	Install Security Cameras Inside & Outside Of Facility	2013	6,815		20	1,363	1,363	4,089	12
13	Install Concrete Patio	2013	4,660		20	466	466	1,320	13
14	Install Outside Smoking Room - Ground Floor Patio	2013	20,745		20	2,075	2,075	5,878	14
15	Repair Collapsed Sewer Line	2013	7,280		20	364	364	1,031	15
16	New Compressor	2013	2,772		20	277	277	716	16
17	Installed 3 Calcana Infrared Radiant Heaters, Sensors, & Gas Lin	2013	15,975		20	799	799	1,997	17
18	Installed Emergency Pull Cord Transmitter	2013	4,204		20	420	420	1,016	18
19	Installed New 2" Tubes & Head Gaskets On Front & Rear Head C	2013	14,390		20	720	720	1,679	19
20	Install New Commercial Grade Electric Gate Operator	2014	7,490		20	499	499	583	20
21	Replace Temp Control, Rebuild Mixing Valve On Hot Water Heat	2014	5,106		20	255	255	468	21
22	Repair Entrance Gate	2015	3,804		20	254	254	254	22
23	Replace Water Heater	2015	9,547		20	438	438	438	23
24	2 New Doors In Kitchen	2015	5,300		20	221	221	221	24
25	New Vestibule Entry	2015	5,750		20	264	264	264	25
26	Main Sewer Repairs	2015	17,950		20	374	374	374	26
27	Rodding Main Sewer	2015	8,950		20	224	224	224	27
28	Curtains	2015	2,654		20	88	88	88	28
29	Boiler Repairs	2015	6,824		20	57	57	57	29
30	New Flanges, Gaskets And Pump	2015	2,512		20	10	10	10	30
31	Walk-On Cooler-Replace Compressor & Drier, Wire In New Com	2015	2,677		20	134	134	134	31
32	Elevator Repair- Install Gate Restrictor, Door Lock Cover	2015	5,448		20	272	272	272	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,803,016	$ 254,611		$ 278,304	$ 23,693	$ 4,066,584	34

**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: 01/01/15 Ending: 12/31/15

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		$ 7,803,016	$ 254,611		$ 278,304	$ 23,693	$ 4,066,584	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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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)		$ 7,803,016	$ 254,611		$ 278,304	$ 23,693	$ 4,066,584	34

**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: 01/01/15 Ending: 12/31/15

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		$ 7,803,016	$ 254,611		$ 278,304	$ 23,693	$ 4,066,584	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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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)		$ 7,803,016	$ 254,611		$ 278,304	$ 23,693	$ 4,066,584	34

**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: 01/01/15 Ending: 12/31/15

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		$ 7,803,016	$ 254,611		$ 278,304	$ 23,693	$ 4,066,584	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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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)		$ 7,803,016	$ 254,611		$ 278,304	$ 23,693	$ 4,066,584	34

**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: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	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	268,634	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	70,630	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	14,432	11
12	Grasmere Real Estate (various)	2005	98,203		20	4,910	4,910	56,116	12
13	Grasmere Real Estate (various)	2006	87,251		20	4,363	4,363	39,842	13
14	Grasmere Real Estate (various)	2007	14,669		20	733	733	6,597	14
15	Piping Repair	2008	7,309		20	365	365	2,920	15
16	Elevator Repair	2008	2,738		20	137	137	1,096	16
17	Boiler Repair	2008	9,826		20	491	491	3,928	17
18	Fire Escape Repairs	2009	9,160		20	458	458	3,206	18
19	Masonry Repairs	2009	2,810		20	141	141	987	19
20	USA Satellite & Cable	2009	4,810		20	281	281	2,767	20
21	Window Screen	2009	5,880		20	294	294	2,058	21
22	Boiler	2009	6,061		20	303	303	2,121	22
23	Masonry Repairs	2010	51,315		20	2,566	2,566	15,396	23
24	Replace Plumbing in rooms 204 & 208	2011	3,610		20	181	181	724	24
25	New Sprinkler Heads	2012	15,512		20	776	776	3,104	25
26	Replace Underground Steam Pipes	2012	13,950		20	698	698	2,792	26
27	Replace Kitchen Floor and Walls	2012	8,970		20	449	449	1,796	27
28	Remove and Replace Walls in Dishwasher Room	2012	3,420		20	171	171	684	28
29	Roofing Repairs	2012	3,596		20	180	180	720	29
30	Remove and Replace Chimney	2012	8,280		20	414	414	1,656	30
31	Replace Steel Doors, Flooring	2012	9,890		20	495	495	1,980	31
32	Replace Window Hardware	2012	9,532		20	477	477	1,908	32
33	New Window Screens	2012	2,610		20	131	131	524	33
34	TOTAL (lines 1 thru 33)		$ 815,879	$		$ 40,839	$ 40,839	$ 506,618	34

**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: 01/01/15 Ending: 12/31/15

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 12F, Carried Forward		$ 815,879	$		$ 40,839	$ 40,839	$ 506,618	1
2	Window Replacement Parts	2012	7,638		20	382	382	1,528	2
3	Install Mass Notification System & Wireless Nurse Call System	2013	67,027		20	3,351	3,351	10,053	3
4	South Side 2nd Floor and North Side 3rd Floor	2013	86,984		20	4,349	4,349	13,047	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 977,528	$		$ 48,921	$ 48,921	$ 531,246	34

****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: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 W. Main, LLC	2002	39,623	1,016	39	1,016		13,504	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	230	12	20	12		104	9
10	Allocated from Extended Care Consulting, LLC	2009	138	7	20	7		48	10
11	Allocated from Extended Care Consulting, LLC	2010	1,352	68	20	68		406	11
12	Allocated from Extended Care Consulting, LLC	2011	487	24	20	24		122	12
13	Allocated from Extended Care Consulting, LLC	2012	160	8	20	8		32	13
14	Allocated from Extended Care Consulting, LLC	2014	2,222	111	20	111		222	14
15									15
16	Allocated from 2201 W. Main, LLC	2002	32,731		20			32,731	16
17	Allocated from 2201 W. Main, LLC	2003	38,573		20			38,573	17
18	Allocated from 2201 W. Main, LLC	2005	1,916	204	20	204		1,913	18
19	Allocated from 2201 W. Main, LLC	2009	346	17	20	17		121	19
20	Allocated from 2201 W. Main, LLC	2014	3,216	161	20	161		322	20
21	Allocated from 2201 W. Main, LLC	2015	545	27	20	27		27	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)		$ 121,539	$ 1,655		$ 1,655	$	$ 88,125	34

**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: 01/01/15 Ending: 12/31/15

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 12H, Carried Forward		$ 121,539	$ 1,655		$ 1,655	$	$ 88,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 121,539	$ 1,655		$ 1,655	$	$ 88,125	34

**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: 01/01/15 Ending: 12/31/15

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	$ 83,629	$ 988	$ 9,085	$ 8,097	10	$ 56,677	71
72	Current Year Purchases	11,413	154	1,797	1,643	10	1,797	72
73	Fully Depreciated Assets	1,853,674				10	1,853,674	73
74								74
75	TOTALS	$ 1,948,716	$ 1,142	$ 10,882	$ 9,740		$ 1,912,148	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	$	$	$	5	$ 17,535	76
77		Allocated from EC Consulting, LI	2015	9,042	255	255		5	8,276	77
78										78
79										79
80	TOTALS			$ 26,577	$ 255	$ 255	$		$ 25,811	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)	$ 10,607,062	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 256,008	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 289,441	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,433	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,004,543	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: 01/01/15 Ending: 12/31/15

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 [X] 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	Off Site Storage Rental				3,698			5
6								6
7	TOTAL				$ 3,698 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 5,741 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.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

STATE OF ILLINOIS

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						960			960	13
14	TOTAL				$		$ 960	$		$ 960	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.

STATE OF ILLINOIS

Facility Name & ID Number Grasmere Place **#** 0044271 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 295,142	$ 433,804	1
2	Cash-Patient Deposits	22,146	22,146	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	617,932	617,932	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	228,477	247,433	6
7	Other Prepaid Expenses	4,969	4,969	7
8	Accounts Receivable (owners or related parties)	8,400	8,400	8
9	Other(specify):	24,688	665,221	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,201,754	$ 1,999,905	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	962,849	1,901,192	15
16	Equipment, at Historical Cost	288,003	1,945,738	16
17	Accumulated Depreciation (book methods)	(1,036,032)	(5,784,486)	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):		808,258	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 214,820	$ 5,248,702	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,416,574	$ 7,248,607	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,440,570	$ 1,440,571	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,037	24,037	28
29	Short-Term Notes Payable		214,799	29
30	Accrued Salaries Payable	242,598	242,598	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,674	8,674	31
32	Accrued Real Estate Taxes(Sch.IX-B)		243,000	32
33	Accrued Interest Payable		28,204	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,715,879	$ 2,201,883	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,748,798	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,748,798	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,715,879	$ 9,950,681	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (299,305)	$ (2,702,074)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,416,574	$ 7,248,607	48

***(See instructions.)**

Facility Name & ID Number Grasmere Place **#** 0044271 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (149,460)	1
2	Restatements (describe):		2
3	**Reversal of Accounting Fees Entry**	23,800	3
4	**Rounding**	(6)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (125,666)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(173,639)	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)**	$ (173,639)	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)**	$ (299,305)	24 *

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

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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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,740,490	1
2	Discounts and Allowances for all Levels	(8,078)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,732,412	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	8,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,078	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	533	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 533	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	92	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 92	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,741,115	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,513,873	31
32	Health Care	2,538,359	32
33	General Administration	1,775,461	33
	B. Capital Expense		
34	Ownership	1,086,101	34
	C. Ancillary Expense		
35	Special Cost Centers	960	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,914,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	(173,639)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (173,639)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,684,968	44
45	Private Pay - Net Inpatient Revenue	47,444	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,732,412	49

* **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.**

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

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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	1,934	2,131	$ 98,127	$ 46.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,600	3,895	127,374	32.70	3
4	Licensed Practical Nurses	16,249	17,844	463,183	25.96	4
5	CNAs & Orderlies	57,543	66,048	695,577	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,919	2,157	57,659	26.73	9
10	Activity Assistants	8,557	9,422	95,300	10.11	10
11	Social Service Workers	33,642	37,768	742,682	19.66	11
12	Dietician					12
13	Food Service Supervisor	2,257	2,492	44,134	17.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,449	5,100	61,800	12.12	15
16	Dishwashers	13,144	15,125	142,179	9.40	16
17	Maintenance Workers	9,267	10,520	159,691	15.18	17
18	Housekeepers	23,071	26,291	276,629	10.52	18
19	Laundry					19
20	Administrator	1,940	2,194	124,855	56.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,160	13,054	187,578	14.37	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	1,891	2,101	23,961	11.40	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9,734	9,879	89,563	9.07	33
34	TOTAL (lines 1 - 33)	200,357	226,021	$ 3,390,292 *	$ 15.00	34

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

** See instructions.

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	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	18,347	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	32	5,680	12-03	45
46	Other(specify)				46
47	Art Therapist	59	2,925	11-03	47
48	Phsyciatrist	Monthly	3,600	10-03	48
49	TOTAL (lines 35 - 48)	91	$ 34,152		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Celeste Jensen	Administrator	0	$ 124,855
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 124,855

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/Marcum	Accounting	$ 24,049
Personnel Planners	Unemployment Consulting	1,487
Ext. Care Consulting	Home Office Expense	316,872
See Attached	Legal	25,080
Urban Real Estate	R/E Appraisal	3,500
Holly Turner	Resident Matters	247
Pinnacle Consulting	Customer Satisfaction	586
The William Everett Group	IT Consulting	160
Pro Payroll	Payroll Services	26,575
National Datacare Corporation	Resident Fund Processing	6,352
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 404,907

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,480
Unemployment Compensation Insurance	28,884
FICA Taxes	259,357
Employee Health Insurance	188,831
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	25,508
Other Employee Welfare	2,287
Holiday Expense	1,974
TOTAL (agree to Schedule V, line 22, col.8)	$ 601,321

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,946
Advertising: Employee Recruitment	2,031
Health Care Worker Background Check	4,699
(Indicate # of checks performed 110)	
Patient Background Checks	
Licenses and Permits	543
Dues and Subscriptions	22,356
Allocated from Extended Care Consulting	1,380
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,955

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,965
Allocated from Extended Care Consulting	474
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,439

**See instructions.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Grasmere Place # 0044271 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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. **Alliance for Living $28,020**

(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. $ **21** 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. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.