		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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0044271

Facility Name: Grasmere Place

Address: 4621 North Sheridan (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	
[ ] Charitable Corp.	
[ ] Trust	
IRS Exemption Code	
[X] PROPRIETARY	
[ ] Individual	
[ ] Partnership	
[ ] Corporation	
[ ] "Sub-S" Corp.	
[X] Limited Liability Co.	
[ ] Trust	
[ ] Other	
[ ] GOVERNMENTAL	
[ ] State	
[ ] County	
[ ] Other	

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/16 to 12/31/16 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)
	* *Subject to the attached Accountants Consulting Report*
	(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: 01/01/16 Ending: 12/31/16

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	79,056	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	79,056	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	66,053	366		66,419	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,053	366		66,419	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.02%

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number: Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	240,412	33,645		274,057		274,057	250	274,307			1
2	Food Purchase		340,301		340,301		340,301	520	340,821			2
3	Housekeeping	298,304	62,992		361,296		361,296	1,385	362,681			3
4	Laundry	5,167	13,974	54,228	73,369		73,369		73,369			4
5	Heat and Other Utilities			156,101	156,101		156,101	1,932	158,033			5
6	Maintenance	148,392		122,899	271,291		271,291	16,132	287,423			6
7	Other (specify):*							1,206	1,206			7
8	**TOTAL General Services**	692,275	450,912	333,228	1,476,415		1,476,415	21,425	1,497,840			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,381,653	44,729	22,368	1,448,750		1,448,750	(1,634)	1,447,116			10
10a	Therapy											10a
11	Activities	234,381	39,077		273,458		273,458		273,458			11
12	Social Services	762,489	12,797	4,380	779,666		779,666		779,666			12
13	CNA Training											13
14	Program Transportation			663	663		663		663			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,378,523	96,603	31,011	2,506,137		2,506,137	(1,634)	2,504,503			16
	C. General Administration											
17	Administrative	96,860			96,860		96,860	27,043	123,903			17
18	Directors Fees											18
19	Professional Services			421,532	421,532	(1,892)	419,640	(308,889)	110,751			19
20	Dues, Fees, Subscriptions & Promotions			66,228	66,228		66,228	(22,783)	43,445			20
21	Clerical & General Office Expenses	198,445	23,470	183,744	405,659		405,659	11,656	417,315			21
22	Employee Benefits & Payroll Taxes			617,962	617,962		617,962	(6,960)	611,002			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,390	2,390		2,390	206	2,596			24
25	Other Admin. Staff Transportation			4,030	4,030		4,030	1,398	5,428			25
26	Insurance-Prop.Liab.Malpractice			187,747	187,747		187,747	22,044	209,791			26
27	Other (specify):*							33,660	33,660			27
28	**TOTAL General Administration**	295,305	23,470	1,483,633	1,802,408	(1,892)	1,800,516	(242,625)	1,557,891			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,366,103	570,985	1,847,872	5,784,960	(1,892)	5,783,068	(222,835)	5,560,233			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:** 01/01/16 **Ending:** 12/31/16

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			42,712	42,712		42,712	243,852	286,564			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							341,730	341,730			32
33	Real Estate Taxes					1,892	1,892	228,654	230,546			33
34	Rent-Facility & Grounds			1,035,448	1,035,448		1,035,448	(1,032,000)	3,448			34
35	Rent-Equipment & Vehicles			4,471	4,471		4,471	1,320	5,791			35
36	Other (specify):*							43,164	43,164			36
37	**TOTAL Ownership**			1,082,631	1,082,631	1,892	1,084,523	(173,280)	911,243			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							0	0			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**							0	0			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,366,103	570,985	2,930,503	6,867,591		6,867,591	(396,115)	6,471,476			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: 01/01/16 Ending: 12/31/16

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	37,676	30		9
10	Interest and Other Investment Income	(3,049)	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	(750)	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	(124,475)	21		24
25	Fund Raising, Advertising and Promotional	(6,245)	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	(51,277)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (148,139)		$	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)	(247,975)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (247,975)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (396,114)		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

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (3)	21	1
2	Jury Duty Income	(25)	10	2
3	Theft Loss	(545)	21	3
4	Collections	(2,448)	21	4
5	Lobbying Expense	(3,260)	20	5
6	PAC Dues	(13,590)	20	6
7	Annual Report	(250)	20	7
8	Non-Allowable Legal	(737)	19	8
9	Prior Period Expense	(8,400)	21	9
10	Building Co - Management Fee	(10,050)	21	10
11	Building Co - Audit Fee	(8,700)	19	11
12	Building Co - Filing Fee	(250)	21	12
13	Building Co - Amortization	(2,990)	36	13
14	Building Co - Penalty	(29)	21	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**	(51,277)		49

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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: 01/01/16 Ending: 12/31/16

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

	Operating Expenses A. General Services	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)	
1	Dietary			250									250	1
2	Food Purchase	(19)		539									520	2
3	Housekeeping			1,385									1,385	3
4	Laundry													4
5	Heat and Other Utilities			1,932									1,932	5
6	Maintenance			4,037	12,095								16,132	6
7	Other (specify):*				1,206								1,206	7
8	**TOTAL General Services**	(19)		8,143	13,301								21,425	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25)				(1,586)		(23)					(1,634)	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**	(25)				(1,586)		(23)					(1,634)	16
	C. General Administration													
17	Administrative			4,041	23,002								27,043	17
18	Directors Fees													18
19	Professional Services	(9,437)	9,353	(308,805)									(308,889)	19
20	Fees, Subscriptions & Promotions	(24,095)		1,312									(22,783)	20
21	Clerical & General Office Expenses	(146,200)	10,329	8,141	139,386								11,656	21
22	Employee Benefits & Payroll Taxes				(6,960)								(6,960)	22
23	Inservice Training & Education													23
24	Travel and Seminar			206									206	24
25	Other Admin. Staff Transportation			1,398									1,398	25
26	Insurance-Prop.Liab.Malpractice		19,625	2,419									22,044	26
27	Other (specify):*				33,660								33,660	27
28	**TOTAL General Administration**	(179,732)	39,307	(291,288)	189,088								(242,625)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(179,776)	39,307	(283,145)	202,389	(1,586)		(23)					(222,835)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	37,676	202,951	3,225									243,852	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,049)	333,072	11,707									341,730	32
33	Real Estate Taxes		223,015	5,639									228,654	33
34	Rent-Facility & Grounds		(1,032,000)										(1,032,000)	34
35	Rent-Equipment & Vehicles			1,320									1,320	35
36	Other (specify):*	(2,990)	46,154										43,164	36
37	**TOTAL Ownership**	31,637	(226,808)	21,891									(173,280)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					0							0	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**					0							0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(148,139)	(187,501)	(261,254)	202,389	(1,586)		(23)					(396,115)	45

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,032,000	Grasmere Real Estate, LLC	100.00%	$	$ (1,032,000)	1
2	V	32	Interest	468	Grasmere Real Estate, LLC	100.00%	333,540	333,072	2
3	V	21	Management Fees		Grasmere Real Estate, LLC	100.00%	10,050	10,050	3
4	V	19	Audit Fees		Grasmere Real Estate, LLC	100.00%	8,700	8,700	4
5	V	21	Filing Fees		Grasmere Real Estate, LLC	100.00%	250	250	5
6	V	30	Depreciation		Grasmere Real Estate, LLC	100.00%	202,951	202,951	6
7	V	36	Amortization		Grasmere Real Estate, LLC	100.00%	2,990	2,990	7
8	V	33	Real Estate Taxes		Grasmere Real Estate, LLC	100.00%	224,322	224,322	8
9	V	26	Insurance		Grasmere Real Estate, LLC	100.00%	19,625	19,625	9
10	V	36	Mortage Insurance		Grasmere Real Estate, LLC	100.00%	43,164	43,164	10
11	V	21	Penalty		Grasmere Real Estate, LLC	100.00%	29	29	11
12	V	33	Real Estate Taxes - Refund	1,307	Grasmere Real Estate, LLC	100.00%		(1,307)	12
13	V	19	Real Estate Appeal Fee		Grasmere Real Estate, LLC	100.00%	653	653	13
14	Total			$ 1,033,775			$ 846,274	$ * (187,501)	14

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 250	$ 250	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	539	539	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,385	1,385	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,932	1,932	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,037	4,037	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,041	4,041	20
21	V	19	Professional Fees	316,872	Extended Care Consulting, LLC	100.00%	8,067	(308,805)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,312	1,312	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	8,141	8,141	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	206	206	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,398	1,398	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,419	2,419	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,225	3,225	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	11,707	11,707	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,639	5,639	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,320	1,320	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			$ 55,618	$ * (261,254)	39

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

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%	12,095	$ 12,095	15
16	V	06	Maintenance (Direct)	882	Extended Care Consulting, LLC	100.00%	882		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,134	1,134	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	72	72	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	23,002	23,002	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	139,386	139,386	22
23	V	21	Office and Clerical (Direct)	22,318	Extended Care Consulting, LLC	100.00%	22,318		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	29,701	29,701	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,959	3,959	25
26	V	22	Employee Benefits	6,960	Extended Care Consulting, LLC	100.00%		(6,960)	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			$ 30,160			$ 232,549	$ * 202,389	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 22,024	MAC Rx, LLC	100.00%	$ 20,438	$ (1,586)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	7,218	MAC Rx, LLC	100.00%	7,218	0	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			$ 29,242			$ 27,656	$ * (1,586)	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 196,809	$ 196,809	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	196,809	CCS Employee Benefits Group	100.00%		(196,809)	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			$ 196,809			$ 196,809	$ *	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Various Equipment	400	Vent Lease LLC	100.00%	377	$ (23)	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			$ 400			$ 377	$ * (23)	39

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 01/01/16 Ending: 12/31/16

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 01/01/16 Ending: 12/31/16

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	VENT LEASE LLC	EVANSTON	VENTILATOR EQIP	5
6	KATHRYN VALES ACCUM TRUST	4.86%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	6
7	KIMBERLY VALES ACCUM TRUST	4.86%	MAJOR HOSPITAL DYER	DYER, IN	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8	NEAL & BEATA ROTHNER	.69%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				8
9	DR. DAVID & SARA ROTHNER	.69%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10	LINDA VARDI	.69%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11	SANDRA & HILLEL KLIERS	.69%	MAJOR HOSPITAL SEBOS	HOBART, IN				11
12	NATHAN & SHIRLEY GRANDCHILDREN TRUST	3.24%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13	WILLIAM ROTHNER	1.85%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14	DANIEL ROTHNER	1.85%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15	RACHEL ROTHNER	1.85%	PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16	MELISSA ROTHNER	1.85%	RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17	ADAM VALES	1.85%	SHEFFIELD MANOR	DYER, IN				17
18	KATHRYN SILVERS	1.85%	SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19	KIMBERLY RUDOLPH	1.85%	SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20	N. & S. ROTHNER FAMILY TRUST	46.99%	SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

STATE OF ILLINOIS

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Mark Steinberg	Relative	Administrative		See Attached	3.83	6.96%	Alloc Sal/Fee	$ 13,888	17-7	1
2	Kimberly Rudolph	Shareholder	Clerical	1.85%	See Attached	0.37	4.87%	Alloc Salary	112	21-7	2
3	Adam Vales	Relative	Clerical		See Attached	1	2.50%	Alloc Salary	1,834	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 15,834		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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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 [ ]

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

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

	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	1,380,761	34	$ 5,206	$	66,419	$ 250	1
2	02	Food	Patient Days	1,380,761	34	11,203		66,419	539	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		66,419	1,385	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		66,419	1,932	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		66,419	4,037	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		66,419	4,041	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		66,419	8,067	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		66,419	1,312	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		66,419	8,141	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		66,419	206	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		66,419	1,398	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		66,419	2,419	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		66,419	3,225	13
14	32	Interest	Patient Days	1,380,761	34	243,379		66,419	11,707	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		66,419	5,639	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		66,419	1,320	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 55,618	25

Facility Name & ID Number: Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [ ]

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

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

	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	1,380,761	34	251,431	251,431	66,419	12,095	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		882	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		66,419	1,134	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			72	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	66,419	23,002	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	66,419	139,386	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		22,318	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		66,419	29,701	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			3,959	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					$ 5,222,483	$ 4,461,323		$ 232,549	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 20,438	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						7,218	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					$	$		$ 27,656	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 196,809	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					$	$		$ 196,809	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	10	Various Equipment	Direct Allocation						377	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					$	$		$ 377	25

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage	$ 71,078.00	1/26/1999	$ 9,518,795	$ 7,748,798			$ 333,540	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	DAIWA		X	Line of Credit				90,000				6
7	Alloc from Extended Care	X									11,707	7
8					-							8
9	TOTAL Facility Related				71078.00		$ 9,518,795	$ 7,838,798			$ 345,247	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,049)	10
11	Interest Income - Building Co		X								(468)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (3,517)	14
15	TOTALS (line 9+line14)						$ 9,518,795	$ 7,838,798			$ 341,730	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 43,164 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.)

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2015 report.	$	244,268	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.)	$	233,582	2
3. Under or (over) accrual (line 2 minus line 1).	$	(10,686)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	239,340	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.)**	$	1,892	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** $ 1,960 **For** 02,04 **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.	$	230,546	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2011	175,849	8
	2012	201,873	9
	2013	204,166	10
	2014	207,194	11
	2015	227,943	12

Line	FOR BHF USE ONLY		Line
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Beginning Accrual Adjusted
2016 Accrual: $227,943 x 1.05 = $239,340 (Rounded)
Allocated from Extended Care Consulting: $5,639

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.**

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	14-17-214-001-0000	Long Term Care Property	$ 202,940.36	$ 202,940.36
2.	14-17-214-002-0000	Long Term Care Property	$ 12,506.73	$ 12,506.73
3.	14-17-214-003-0000	Long Term Care Property	$ 12,495.74	$ 12,495.74
4.	See Attached	Allocation from 2201 W. Main	$ 167,518.13	$ 5,639.31
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 395,460.96	$ 233,582.14

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1999	$ 800,000	1
2	Allocated from 2201 W. Main, LLC			27,604	2
3	TOTALS			$ 827,604	3

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 202,951	35	$ 159,371	$ (43,580)	$ 2,854,997	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	83,114		20	3,790	3,790	65,440	9
10	Various			2000	251,874		20	12,463	12,463	210,529	10
11	Various			2001	59,759		20	2,988	2,988	46,737	11
12	Various			2002	147,991		20	895	895	143,787	12
13	Various			2003	29,651		20	1,483	1,483	20,332	13
14	Various			2004	70,279		20	170	170	68,958	14
15	Various			2005	42,283		20			42,283	15
16	Various			2006	25,997		20	1,362	1,362	25,997	16
17	Various			2008	13,572		20	1,357	1,357	10,996	17
18	Various			2009	24,708		20	2,471	2,471	17,980	18
19	Various			2010	2,584		20	369	369	2,430	19
20	Various			2011	72,172		20	5,156	5,156	32,643	20
21	Various			2012	141,113		20	21,616	21,616	96,484	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: 01/01/16 Ending: 12/31/16

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	580,167	67
68	Related Party Allocations (Pages 12H & 12I)		132,855	1,883		1,883		88,660	68
69	Financial Statement Depreciation			42,712			(42,712)		69
70	TOTAL (lines 4 thru 69)		$ 7,653,479	$ 247,546		$ 264,296	$ 16,750	$ 4,308,420	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: 01/01/16 Ending: 12/31/16

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		$ 7,653,479	$ 247,546		$ 264,296	$ 16,750	$ 4,308,420	1
2	Install Security Cameras Inside & Outside Of Facility	2013	6,815		20	1,363	1,363	5,452	2
3	Install Concrete Patio	2013	4,660		20	466	466	1,786	3
4	Install Outside Smoking Room - Ground Floor Patio	2013	20,745		20	2,075	2,075	7,952	4
5	Repair Collapsed Sewer Line	2013	7,280		20	364	364	1,395	5
6	New Compressor	2013	2,772		20	277	277	993	6
7	Installed 3 Calcana Infrared Radiant Heaters, Sensors, & Gas Lin	2013	15,975		20	799	799	2,796	7
8	Installed Emergency Pull Cord Transmitter	2013	4,204		20	420	420	1,436	8
9	Installed New 2" Tubes & Head Gaskets On Front & Rear Head C	2013	14,390		20	720	720	2,398	9
10	Install New Commercial Grade Electric Gate Operator	2014	7,490		20	499	499	1,082	10
11	Replace Temp Control, Rebuild Mixing Valve On Hot Water Heat	2014	5,106		20	255	255	723	11
12	Repair Entrance Gate	2015	3,804		20	254	254	507	12
13	Replace Water Heater	2015	9,547		20	477	477	915	13
14	2 New Doors In Kitchen	2015	5,300		20	265	265	486	14
15	New Vestibule Entry	2015	5,750		20	288	288	551	15
16	Main Sewer Repairs	2015	17,950		20	898	898	1,271	16
17	Rodding Main Sewer	2015	8,950		20	448	448	671	17
18	Curtains	2015	2,654		20	133	133	155	18
19	Boiler Repairs	2015	6,824		20	341	341	398	19
20	New Flanges, Gaskets And Pump	2015	2,512		20	126	126	136	20
21	Walk-In Cooler - Replace Compressor & Drier, Wire In New Com	2015	2,677		20	134	134	257	21
22	Elevator Repair - Install Gate Restrictor, Door Lock Cover	2015	5,448		20	272	272	295	22
23	Gate, Lock And Hand Rails	2016	5,200		20	152	152	152	23
24	Lower Roof - Remove Curbs/Hvac/Insulation	2016	6,800		20	198	198	198	24
25	Main Roof - Caulk/Coping Metal/Pipes	2016	6,950		20	203	203	203	25
26	Demo Pipe, Light Fixtures, Gfi Receptacle	2016	4,120		20	103	103	103	26
27	Ansul System Switch & Fire Alarm System Device	2016	3,676		20	92	92	92	27
28	Lower Roof - Metal Coping/Coating	2016	5,525		20	69	69	69	28
29	Upper Roof - Repaired Walls	2016	3,400		20	43	43	43	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,850,003	$ 247,546		$ 276,027	$ 28,481	$ 4,340,936	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: 01/01/16 Ending: 12/31/16

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		$ 7,850,003	$ 247,546		$ 276,027	$ 28,481	$ 4,340,936	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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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)		$ 7,850,003	$ 247,546		$ 276,027	$ 28,481	$ 4,340,936	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: 01/01/16 Ending: 12/31/16

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		$ 7,850,003	$ 247,546		$ 276,027	$ 28,481	$ 4,340,936	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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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)		$ 7,850,003	$ 247,546		$ 276,027	$ 28,481	$ 4,340,936	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: 01/01/16 Ending: 12/31/16

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		$ 7,850,003	$ 247,546		$ 276,027	$ 28,481	$ 4,340,936	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 7,850,003	$ 247,546		$ 276,027	$ 28,481	$ 4,340,936	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: 01/01/16 Ending: 12/31/16

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									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	283,728	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	76,128	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	15,665	11
12	Grasmere Real Estate (various)	2005	98,203		20	4,910	4,910	61,026	12
13	Grasmere Real Estate (various)	2006	87,251		20	4,363	4,363	44,205	13
14	Grasmere Real Estate (various)	2007	14,669		20	733	733	7,330	14
15	Piping Repair	2008	7,309		20	365	365	3,285	15
16	Elevator Repair	2008	2,738		20	137	137	1,233	16
17	Boiler Repair	2008	9,826		20	491	491	4,419	17
18	Fire Escape Repairs	2009	9,160		20	458	458	3,664	18
19	Masonry Repairs	2009	2,810		20	141	141	1,128	19
20	USA Satellite & Cable	2009	4,810		20	281	281	3,048	20
21	Window Screen	2009	5,880		20	294	294	2,352	21
22	Boiler	2009	6,061		20	303	303	2,424	22
23	Masonry Repairs	2010	51,315		20	2,566	2,566	17,962	23
24	Replace Plumbing in rooms 204 & 208	2011	3,610		20	181	181	905	24
25	New Sprinkler Heads	2012	15,512		20	776	776	3,880	25
26	Replace Underground Steam Pipes	2012	13,950		20	698	698	3,490	26
27	Replace Kitchen Floor and Walls	2012	8,970		20	449	449	2,245	27
28	Remove and Replace Walls in Dishwasher Room	2012	3,420		20	171	171	855	28
29	Roofing Repairs	2012	3,596		20	180	180	900	29
30	Remove and Replace Chimney	2012	8,280		20	414	414	2,070	30
31	Replace Steel Doors, Flooring	2012	9,890		20	495	495	2,475	31
32	Replace Window Hardware	2012	9,532		20	477	477	2,385	32
33	New Window Screens	2012	2,610		20	131	131	655	33
34	TOTAL (lines 1 thru 33)		$ 815,879	$		$ 40,839	$ 40,839	$ 547,457	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: 01/01/16 Ending: 12/31/16

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	$ 547,457	1
2	Window Replacement Parts	2012	7,638		20	382	382	1,910	2
3	Install Mass Notification System & Wireless Nurse Call System	2013	67,027		20	3,351	3,351	13,404	3
4	South Side 2nd Floor and North Side 3rd Floor	2013	86,984		20	4,349	4,349	17,396	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	$ 580,167	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: 01/01/16 Ending: 12/31/16

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	38,040	975	39	975		13,940	3
4	Allocated from Extended Care Consulting	2016	11,545	256	39	256		2,429	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	221	11	20	11		111	9
10	Allocated from Extended Care Consulting	2009	132	7	20	7		53	10
11	Allocated from Extended Care Consulting	2010	1,298	65	20	65		454	11
12	Allocated from Extended Care Consulting	2011	467	23	20	23		140	12
13	Allocated from Extended Care Consulting	2012	154	8	20	8		38	13
14	Allocated from Extended Care Consulting	2014	2,133	107	20	107		320	14
15	Allocated from Extended Care Consulting	2016	2,558	128	20	128		128	15
16									16
17	Allocated from 2201 W. Main, LLC	2002	31,424		20			31,424	17
18	Allocated from 2201 W. Main, LLC	2003	37,032		20			37,032	18
19	Allocated from 2201 W. Main, LLC	2005	1,840	3	20	3		1,840	19
20	Allocated from 2201 W. Main, LLC	2009	332	17	20	17		133	20
21	Allocated from 2201 W. Main, LLC	2014	3,088	154	20	154		463	21
22	Allocated from 2201 W. Main, LLC	2015	523	26	20	26		52	22
23	Allocated from 2201 W. Main, LLC	2016	2,068	103	20	103		103	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)		$ 132,855	$ 1,883		$ 1,883	$	$ 88,660	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: 01/01/16 Ending: 12/31/16

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		$ 132,855	$ 1,883		$ 1,883	$	$ 88,660	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 132,855	$ 1,883		$ 1,883	$	$ 88,660	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: 01/01/16 Ending: 12/31/16

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	$ 92,037	$ 1,096	$ 10,291	$ 9,195	10	$ 66,028	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,850,112				10	1,850,112	73
74								74
75	TOTALS	$ 1,942,149	$ 1,096	$ 10,291	$ 9,195		$ 1,916,140	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		Alloc from Extended Care Consu	2016	8,681	245	245		5	8,191	77
78										78
79										79
80	TOTALS			$ 26,216	$ 245	$ 245	$		$ 25,726	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)	$ 10,645,972	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 248,887	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 286,563	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 37,676	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,282,802	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: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Offsite Storage Rental				3,448			5
6								6
7	TOTAL				$ 3,448 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 5,791 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: 01/01/16 Ending: 12/31/16

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.

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									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ 145,142	$ 240,969	1
2	Cash-Patient Deposits	22,392	22,392	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	943,708	943,708	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	242,011	257,825	6
7	Other Prepaid Expenses	4,563	4,563	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,357,816	$ 1,469,457	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	1,001,947	1,940,290	15
16	Equipment, at Historical Cost	289,201	1,946,936	16
17	Accumulated Depreciation (book methods)	(1,083,369)	(6,034,774)	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):		1,566,387	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 207,779	$ 5,796,839	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,565,595	$ 7,266,296	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,453,927	$ 1,453,926	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,272	21,272	28
29	Short-Term Notes Payable	90,000	90,000	29
30	Accrued Salaries Payable	246,918	246,918	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,038	9,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)		239,340	32
33	Accrued Interest Payable		27,444	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	21	21	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,821,176	$ 2,087,959	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)**	$ 1,821,176	$ 9,836,757	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (255,581)	$ (2,570,461)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,565,595	$ 7,266,296	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (299,305)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (299,306)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,427	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	7,298	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)**	$ 43,725	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)**	$ (255,581)	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	$ 6,893,640	1
2	Discounts and Allowances for all Levels	5,137	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,898,777	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	1,189	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)**	$ 1,189	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,049	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,049	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	1,003	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,003	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,904,018	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,476,415	31
32	Health Care	2,506,137	32
33	General Administration	1,802,408	33
	B. Capital Expense		
34	Ownership	1,082,631	34
	C. Ancillary Expense		
35	Special Cost Centers		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)***	$ 6,867,591	40
41	**Income before Income Taxes (line 30 minus line 40)****	36,427	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 36,427	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,851,197	44
45	Private Pay - Net Inpatient Revenue	47,580	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)	$ 6,898,777	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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,918	2,101	$ 90,729	$ 43.18	1
2	Assistant Director of Nursing	40	40	1,827	45.68	2
3	Registered Nurses	2,130	2,357	85,367	36.22	3
4	Licensed Practical Nurses	17,849	19,598	512,184	26.13	4
5	CNAs & Orderlies	54,456	61,068	666,881	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,825	2,091	57,143	27.33	9
10	Activity Assistants	9,090	10,117	107,437	10.62	10
11	Social Service Workers	32,967	36,689	762,489	20.78	11
12	Dietician					12
13	Food Service Supervisor	2,318	2,596	48,047	18.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,726	6,370	78,412	12.31	15
16	Dishwashers	10,006	11,071	113,953	10.29	16
17	Maintenance Workers	9,515	10,592	148,392	14.01	17
18	Housekeepers	25,068	27,923	298,304	10.68	18
19	Laundry	439	439	5,167	11.77	19
20	Administrator	1,951	2,162	96,860	44.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,025	13,775	198,445	14.41	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	1,863	2,120	24,665	11.63	31
32	Other Health Care(specify)					32
33	Other(specify)	6,776	6,776	69,801	10.30	33
34	TOTAL (lines 1 - 33)	195,962	217,885	$ 3,366,103 *	$ 15.45	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	18,768	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	25	4,380	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	3,600	10-03	47
48					48
49	TOTAL (lines 35 - 48)	25	$ 30,348		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				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	0.00%	$	7,341
Laura Feliciano-Dixon	Administrator	0.00%		89,519
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	96,860

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
Marcum LLP	Accounting	$	24,475
ProPay	Payroll Services		29,319
Achieve Accreditation	Joint Commission Consult		20,146
National Datacare Corp	Resident Fund Processing		3,488
Extended Care Consulting	Home Office Expense		316,872
Personnel Planners	Unemployment Tax Consult		1,374
Navex Global	Compliance Consulting		102
MSDS	Management Consulting		800
Pinnacle Quality Insight	Customer Satisfaction		537
Legat Architects	Architectural Consulting		4,899
See Attached	Legal		17,417
See Supplemental Schedule			2,104
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	421,532

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	89,230
Unemployment Compensation Insurance		30,523
FICA Taxes		250,547
Employee Health Insurance		210,429
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Benefits		146
Pension		25,686
Other Employee Benefits		4,441
TOTAL (agree to Schedule V, line 22, col.8)	$	611,002

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		$	5,700
Advertising: Employee Recruitment			5,000
Health Care Worker Background Check			5,439
(Indicate # of checks performed	82)		
Patient Background Checks	195		1,950
Dues and Subscriptions			22,567
License and Permits			1,477
Alloc from Extended Care Consulting			1,312
Less: Public Relations Expense			( )
Non-allowable advertising			( )
Yellow page advertising			( )
TOTAL (agree to Sch. V, line 20, col. 8)		$	43,445

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		2,390
Allocated from Extended Care Consult		206
Entertainment Expense		( )
TOTAL (agree to Sch. V, line 24, col. 8)	$	2,596

**See instructions.

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. $ **670** 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