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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0054213

Facility Name: Grasmere Place

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 2/1/1999

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/17 to 12/31/17 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, 9 Parkway North, Suite 200 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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	64,892	365		65,257	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,892	365		65,257	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.77%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 2/1/1999

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/1999 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 _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	286,684	42,798		329,482		329,482	241	329,723			1
2	Food Purchase		348,968		348,968		348,968	684	349,652			2
3	Housekeeping	293,603	57,416		351,019		351,019	1,454	352,473			3
4	Laundry		5,090	39,618	44,708		44,708		44,708			4
5	Heat and Other Utilities			164,099	164,099		164,099	1,801	165,900			5
6	Maintenance	187,888		122,238	310,126		310,126	13,066	323,192			6
7	Other (specify):*							1,030	1,030			7
8	TOTAL General Services	768,175	454,272	325,955	1,548,402		1,548,402	18,276	1,566,678			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,405,592	19,377	7,946	1,432,915		1,432,915		1,432,915			10
10a	Therapy											10a
11	Activities	246,837	35,166		282,003		282,003		282,003			11
12	Social Services	732,549	12,710	2,660	747,919		747,919		747,919			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,384,978	67,253	14,206	2,466,437		2,466,437		2,466,437			16
	C. General Administration											
17	Administrative	104,233			104,233		104,233	25,060	129,293			17
18	Directors Fees											18
19	Professional Services			408,274	408,274		408,274	(312,974)	95,300			19
20	Dues, Fees, Subscriptions & Promotions			79,652	79,652		79,652	(36,616)	43,036			20
21	Clerical & General Office Expenses	189,884	18,618	188,909	397,411		397,411	10,315	407,726			21
22	Employee Benefits & Payroll Taxes			669,212	669,212		669,212	(7,155)	662,057			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,894	3,894		3,894	46	3,940			24
25	Other Admin. Staff Transportation			1,599	1,599		1,599	1,204	2,803			25
26	Insurance-Prop.Liab.Malpractice			195,809	195,809		195,809	20,572	216,381			26
27	Other (specify):*							34,119	34,119			27
28	TOTAL General Administration	294,117	18,618	1,547,349	1,860,084		1,860,084	(265,429)	1,594,655			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,447,270	540,143	1,887,510	5,874,923		5,874,923	(247,153)	5,627,770			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 #0054213 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			45,155	45,155		45,155	247,595	292,750			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			434	434		434	334,072	334,506			32
33	Real Estate Taxes							302,027	302,027			33
34	Rent-Facility & Grounds			1,033,546	1,033,546		1,033,546	(1,032,000)	1,546			34
35	Rent-Equipment & Vehicles			6,035	6,035		6,035	1,330	7,365			35
36	Other (specify):*							41,955	41,955			36
37	**TOTAL Ownership**			1,085,170	1,085,170		1,085,170	(105,021)	980,149			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											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**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,447,270	540,143	2,972,680	6,960,093		6,960,093	(352,174)	6,607,919			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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	41,862	30		9
10	Interest and Other Investment Income	(8,938)	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	(1,540)	21		18
19	Entertainment				19
20	Contributions	(18,050)	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	(129,549)	21		24
25	Fund Raising, Advertising and Promotional	(7,933)	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	(40,454)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (164,621)		$	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)	(187,553)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (187,553)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (352,174)		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# 0054213

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft Loss	$ (333)	21	1
2	Collection Expense	(2,448)	21	2
3	Alliance for Living - Lobbying	(11,712)	20	3
4	Non-Allowable Legal	(875)	19	4
5	Capitalized R&M	(2,539)	6	5
6	Building Company - Management Feees	(10,050)	21	6
7	Building Company - Audit Fee	(8,900)	19	7
8	Building Company - Bank Charges	(60)	21	8
9	Building Company - Filing Fee	(250)	21	9
10	Building Company - Amortization	(2,990)	36	10
11	Building Company - State Replacement Tax	(261)	21	11
12	Real Estate Tax - Convenience Fee	(36)	33	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(40,454)		49

Grasmere Place

ID# 0054213

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 # 0054213 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			241									241	1
2	Food Purchase	(19)		703									684	2
3	Housekeeping			1,454									1,454	3
4	Laundry													4
5	Heat and Other Utilities			1,801									1,801	5
6	Maintenance	(2,539)		4,961	10,644								13,066	6
7	Other (specify):*				1,030								1,030	7
8	**TOTAL General Services**	(2,558)		9,160	11,674								18,276	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													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**													16
	C. General Administration													
17	Administrative			3,713	21,347								25,060	17
18	Directors Fees													18
19	Professional Services	(9,775)	8,900	(312,099)									(312,974)	19
20	Fees, Subscriptions & Promotions	(37,695)		1,079									(36,616)	20
21	Clerical & General Office Expenses	(144,491)	10,621	10,668	133,517								10,315	21
22	Employee Benefits & Payroll Taxes				(7,155)								(7,155)	22
23	Inservice Training & Education													23
24	Travel and Seminar			46									46	24
25	Other Admin. Staff Transportation			1,204									1,204	25
26	Insurance-Prop.Liab.Malpractice		18,400	2,172									20,572	26
27	Other (specify):*				34,119								34,119	27
28	**TOTAL General Administration**	(191,961)	37,921	(293,217)	181,828								(265,429)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(194,519)	37,921	(284,057)	193,502								(247,153)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Grasmere Place **#** 0054213 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	41,862	202,645	3,088									247,595	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,938)	323,673	19,337									334,072	32
33	Real Estate Taxes	(36)	296,637	5,426									302,027	33
34	Rent-Facility & Grounds		(1,032,000)										(1,032,000)	34
35	Rent-Equipment & Vehicles			1,330									1,330	35
36	Other (specify):*	(2,990)	44,945										41,955	36
37	**TOTAL Ownership**	29,898	(164,100)	29,181									(105,021)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													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**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(164,621)	(126,179)	(254,876)	193,502								(352,174)	45

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,032,000	Grasmere Real Estate, LLC	100.00%	$	$ (1,032,000)	1
2	V	32	Interest	525	Grasmere Real Estate, LLC	100.00%	324,198	323,673	2
3	V	21	Management Fees		Grasmere Real Estate, LLC	100.00%	10,050	10,050	3
4	V	19	Audit Fee		Grasmere Real Estate, LLC	100.00%	8,900	8,900	4
5	V	21	Bank Service Charges		Grasmere Real Estate, LLC	100.00%	60	60	5
6	V	21	Filing Fees		Grasmere Real Estate, LLC	100.00%	250	250	6
7	V	30	Depreciation		Grasmere Real Estate, LLC	100.00%	202,645	202,645	7
8	V	36	Amortization		Grasmere Real Estate, LLC	100.00%	2,990	2,990	8
9	V	33	Real Estate Tax		Grasmere Real Estate, LLC	100.00%	296,637	296,637	9
10	V	21	State Replacement Tax		Grasmere Real Estate, LLC	100.00%	261	261	10
11	V	26	Insurance		Grasmere Real Estate, LLC	100.00%	18,400	18,400	11
12	V	36	Mortgage Insurance		Grasmere Real Estate, LLC	100.00%	41,955	41,955	12
13	V								13
14	Total			$ 1,032,525			$ 906,346	$ * (126,179)	14

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 241	$ 241	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	703	703	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,454	1,454	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,801	1,801	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,961	4,961	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,713	3,713	20
21	V	19	Professional Fees	316,872	Extended Care Consulting, LLC	100.00%	4,773	(312,099)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,079	1,079	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,668	10,668	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	46	46	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,204	1,204	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,172	2,172	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,088	3,088	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	19,337	19,337	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,426	5,426	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,330	1,330	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			$ 61,996	$ * (254,876)	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	10,644	$ 10,644	15
16	V	06	Maintenance (Direct)	492	Extended Care Consulting, LLC	100.00%	492		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	987	987	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	43	43	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	21,347	21,347	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	133,517	133,517	22
23	V	21	Office and Clerical (Direct)	23,357	Extended Care Consulting, LLC	100.00%	23,357		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	29,923	29,923	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,196	4,196	25
26	V	22	Employee Benefits	7,155	Extended Care Consulting, LLC	100.00%		(7,155)	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			$ 31,004			$ 224,506	$ * 193,502	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 249,194	$ 249,194	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	249,194	CCS Employee Benefits Group	100.00%		(249,194)	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			$ 249,194			$ 249,194	$ *	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	CHICAGO	BUILDING COMPANY	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 COMPANY	4
5	ADAM VALES ACCUM TRUST	4.86%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	KATHRYN VALES ACCUM TRUST	4.86%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	KIMBERLY VALES ACCUM TRUST	4.86%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8	NEAL & BEATA ROTHNER	.69%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	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%	LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	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			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Steinberg	Relative	Administrative	0	See Attached	3.67	6.67%	Alloc Sal/Fee	$ 13,339	17-7	1
2	Adam Vales	Relative	Clerical	0	See Attached	1.11	2.77%	Alloc Salary	1,915	21-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 15,254		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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,476,506	37	$ 5,451	$	65,257	$ 241	1
2	02	Food	Patient Days	1,476,506	37	15,903		65,257	703	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		65,257	1,454	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		65,257	1,801	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		65,257	4,961	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		65,257	3,713	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		65,257	4,773	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		65,257	1,079	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		65,257	10,668	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		65,257	46	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		65,257	1,204	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		65,257	2,172	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		65,257	3,088	13
14	32	Interest	Patient Days	1,476,506	37	437,528		65,257	19,337	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		65,257	5,426	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		65,257	1,330	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 61,996	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,476,506	37	240,841	240,841	65,257	10,644	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		492	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		65,257	987	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			43	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	65,257	21,347	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	65,257	133,517	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		23,357	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		65,257	29,923	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			4,196	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					$ 5,426,248	$ 4,601,481		$ 224,506	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 249,194	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					$	$		$ 249,194	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$ 7,524,691			$ 324,198	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Daiwa		X	Line of Credit				584,146			434	6
7												7
8												8
9	TOTAL Facility Related						$	$ 8,108,837			$ 324,632	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,938)	10
11	Interest Income (Bldg Co)										(525)	11
12	Alloc from Extended Care Consulting										19,337	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,874	14
15	TOTALS (line 9+line14)						$	$ 8,108,837			$ 334,506	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 41,955 Line # 36

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

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

Facility Name & ID Number Grasmere Place **#** 0054213 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 239,340	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.)		$ 266,861	2
3. Under or (over) accrual (line 2 minus line 1).		$ 27,521	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 274,506	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 302,027	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	201,873	8
	2013	204,166	9
	2014	207,194	10
	2015	227,943	11
	2016	261,435	12

2017 accrual = 2016 tax + 5% (261,435 x 1.05 = 274,506)

Allocated from Extended Care Consulting $5426

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054213

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-214-001-0000	Long Term Care Property	$ 234,063.00	$ 234,063.00
2.	14-17-214-002-0000	Long Term Care Property	$ 13,692.32	$ 13,692.32
3.	14-17-214-003-0000	Long Term Care Property	$ 13,679.32	$ 13,679.32
4.	See Attached	Allocated from Care Center Bldg	$ 181,041.32	$ 5,426.01
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 442,475.96	$ 266,860.65

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054213

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 800,000	1
2	Extended Care Consulting - Care Center Bldg			24,576	2
3	TOTALS			$ 824,576	3

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 202,645	35	$ 159,371	$ (43,274)	$ 3,014,368	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	83,114		20	3,790	3,790	69,230	9
10	Various			2000	251,874		20	12,463	12,463	222,992	10
11	Various			2001	59,759		20	2,988	2,988	49,725	11
12	Various			2002	147,991		20	787	787	144,573	12
13	Various			2003	29,651		20	1,483	1,483	21,814	13
14	Various			2004	70,279		20	170	170	69,128	14
15	Various			2005	42,283		20			42,283	15
16	Various			2006	25,997		20			25,997	16
17	Various			2008	13,572		20	1,357	1,357	12,353	17
18	Various			2009	24,708		20	2,471	2,471	20,451	18
19	Various			2010	2,584		20	154	154	2,584	19
20	Various			2011	72,172		20	5,156	5,156	37,799	20
21	Various			2012	141,113		20	14,599	14,599	111,084	21
22	Various			2013	76,841		20	6,483	6,483	30,693	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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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)		1,228,811			61,485	61,485	641,652	67
68	Related Party Allocations (Pages 12H & 12I)		122,089	1,855		1,855		80,989	68
69	Financial Statement Depreciation			45,155			(45,155)		69
70	TOTAL (lines 4 thru 69)		$ 7,970,837	$ 249,655		$ 274,612	$ 24,957	$ 4,597,715	70

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 7,970,837	$ 249,655		$ 274,612	$ 24,957	$ 4,597,715	1
2	Install New Commercial Grade Electric Gate Operator	2014	7,490		20	499	499	1,581	2
3	Replace Temp Control, Rebuild Mixing Valve On Hot Water Heat	2014	5,106		20	255	255	979	3
4	Repair Entrance Gate	2015	3,804		20	254	254	761	4
5	Replace Water Heater	2015	9,547		20	477	477	1,392	5
6	2 New Doors In Kitchen	2015	5,300		20	265	265	751	6
7	New Vestibule Entry	2015	5,750		20	288	288	839	7
8	Main Sewer Repairs	2015	17,950		20	898	898	2,169	8
9	Rodding Main Sewer	2015	8,950		20	448	448	1,119	9
10	Curtains	2015	2,654		20	133	133	288	10
11	Boiler Repairs	2015	6,824		20	341	341	739	11
12	New Flanges, Gaskets And Pump	2015	2,512		20	126	126	262	12
13	Walk-In Cooler - Replace Compressor & Drier, Wire In New Com	2015	2,677		20	134	134	390	13
14	Elevator Repair - Install Gate Restrictor, Door Lock Cover	2015	5,448		20	272	272	568	14
15	Gate, Lock And Hand Rails	2016	5,200		20	260	260	412	15
16	Lower Roof Repairs - Remove Curbs / Hvac / Insulation	2016	6,800		20	340	340	538	16
17	Main Roof Repair - Caulk / Coping Metal / Pipes	2016	6,950		20	348	348	550	17
18	Demo Pipe, Light Fixtures, Gfi Receptacle	2016	4,120		20	206	206	309	18
19	Ansul System Switch & Fire Alarm System Device	2016	3,676		20	184	184	276	19
20	Lower Roof Repair - Metal Coping / Coating	2016	5,525		20	276	276	345	20
21	Upper Roof Repair - Repaired Walls	2016	3,400		20	170	170	213	21
22	Plumbing Repairs - Workshop Room, Rear Of Kitchen	2017	12,900		20	430	430	430	22
23	Hvac - Condensate Return Tank Pump	2017	3,463		20	115	115	115	23
24	Fire Alarm System Modifications	2017	33,967		20	849	849	849	24
25	Walk In Cooler Repair	2017	3,831		20	447	447	447	25
26	A/C Unit Repair - New Blades & Motor	2017	4,034		20	336	336	336	26
27	Walk In Freezer - Upgrade Refrigeration System	2017	7,642		20	127	127	127	27
28	3Rd Floor Remodeling - Wall Replacement & Paint	2017	16,350		20	68	68	68	28
29	3Rd Floor Remodeling - Wall Replacement & Paint	2017	19,850		20	83	83	83	29
30	3Rd Floor Remodeling - Wall Replacement & Paint	2017	19,879		20	83	83	83	30
31	3Rd Floor Remodeling - Wall Replacement & Paint	2017	18,815		20	78	78	78	31
32	Plumbing Repairs	2017	7,500		20	31	31	31	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,238,751	$ 249,655		$ 283,433	$ 33,778	$ 4,614,842	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 8,238,751	$ 249,655		$ 283,433	$ 33,778	$ 4,614,842	1
2									2
3									3
4									4
5									5
6									6
7									7
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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)		$ 8,238,751	$ 249,655		$ 283,433	$ 33,778	$ 4,614,842	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 8,238,751	$ 249,655		$ 283,433	$ 33,778	$ 4,614,842	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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)		$ 8,238,751	$ 249,655		$ 283,433	$ 33,778	$ 4,614,842	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 8,238,751	$ 249,655		$ 283,433	$ 33,778	$ 4,614,842	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,238,751	$ 249,655		$ 283,433	$ 33,778	$ 4,614,842	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	298,822	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	81,626	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	16,898	11
12	Grasmere Real Estate (various)	2005	98,203		20	4,910	4,910	65,936	12
13	Grasmere Real Estate (various)	2006	87,251		20	4,363	4,363	48,568	13
14	Grasmere Real Estate (various)	2007	14,669		20	733	733	8,063	14
15	Piping Repair	2008	7,309		20	365	365	3,650	15
16	Elevator Repair	2008	2,738		20	137	137	1,370	16
17	Boiler Repair	2008	9,826		20	491	491	4,910	17
18	Fire Escape Repairs	2009	9,160		20	458	458	4,122	18
19	Masonry Repairs	2009	2,810		20	141	141	1,269	19
20	USA Satellite & Cable	2009	4,810		20	281	281	3,329	20
21	Window Screen	2009	5,880		20	294	294	2,646	21
22	Boiler	2009	6,061		20	303	303	2,727	22
23	Masonry Repairs	2010	51,315		20	2,566	2,566	20,528	23
24	Replace Plumbing in rooms 204 & 208	2011	3,610		20	181	181	1,086	24
25	New Sprinkler Heads	2012	15,512		20	776	776	4,656	25
26	Replace Underground Steam Pipes	2012	13,950		20	698	698	4,188	26
27	Replace Kitchen Floor and Walls	2012	8,970		20	449	449	2,694	27
28	Remove and Replace Walls in Dishwasher Room	2012	3,420		20	171	171	1,026	28
29	Roofing Repairs	2012	3,596		20	180	180	1,080	29
30	Remove and Replace Chimney	2012	8,280		20	414	414	2,484	30
31	Replace Steel Doors, Flooring	2012	9,890		20	495	495	2,970	31
32	Replace Window Hardware	2012	9,532		20	477	477	2,862	32
33	New Window Screens	2012	2,610		20	131	131	786	33
34	TOTAL (lines 1 thru 33)		$ 815,879	$		$ 40,839	$ 40,839	$ 588,296	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	$ 588,296	1
2	Window Replacement Parts	2012	7,638		20	382	382	2,292	2
3	Install Mass Notification System & Wireless Nurse Call System	2013	67,027		20	3,351	3,351	16,755	3
4	South Side 2nd Floor and North Side 3rd Floor	2013	86,984		20	4,349	4,349	21,745	4
5	Exterior Steel Door Replacement	2017	3,800		20	190	190	190	5
6	Repair Brick & Tuckpoint on Back Wall of Building	2017	12,000		20	600	600	600	6
7	Kitchen Floor Tile Replacement	2017	15,000		20	750	750	750	7
8	Door/Hinge Replacement - 3rd Floor Stairwell & Northside Eastwood	2017	4,601		20	230	230	230	8
9	Paint Exterior Wall & Ceiling on Back Side of Building	2017	10,000		20	500	500	500	9
10	Electrical Box Main Breaker Replacement	2017	7,000		20	350	350	350	10
11	Door Repairs-3rd Flr Stairwell, Activity Rm, Nurses Station, Maint Rr	2017	5,000		20	250	250	250	11
12	3rd Floor - Remove Wallpaper, Patch Walls, Paint	2017	38,382		20	1,919	1,919	1,919	12
13	Tuckpoint Interior Courtyard Walls and Chimney	2017	155,500		20	7,775	7,775	7,775	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,228,811	$		$ 61,485	$ 20,646	$ 641,652	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Extended Care Consulting - Care Center Bldg	2002	33,867	868	39	868		13,279	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	10,607	235	39	235		2,467	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	203	10	20	10		112	9
10	Allocated from Extended Care Consulting	2009	122	6	20	6		55	10
11	Allocated from Extended Care Consulting	2010	1,192	60	20	60		477	11
12	Allocated from Extended Care Consulting	2011	429	21	20	21		150	12
13	Allocated from Extended Care Consulting	2012	141	7	20	7		42	13
14	Allocated from Extended Care Consulting	2014	1,960	98	20	98		392	14
15	Allocated from Extended Care Consulting	2016	2,350	118	20	118		235	15
16	Allocated from Extended Care Consulting - Care Center Bldg	2002	27,977		20			27,977	16
17	Allocated from Extended Care Consulting - Care Center Bldg	2003	32,970		20			32,970	17
18	Allocated from Extended Care Consulting - Care Center Bldg	2005	1,638		20			1,638	18
19	Allocated from Extended Care Consulting - Care Center Bldg	2009	296	15	20	15		133	19
20	Allocated from Extended Care Consulting - Care Center Bldg	2014	2,837	142	20	142		567	20
21	Allocated from Extended Care Consulting - Care Center Bldg	2015	466	23	20	23		151	21
22	Allocated from Extended Care Consulting - Care Center Bldg	2016	1,841	92	20	92		184	22
23	Allocated from Extended Care Consulting - Care Center Bldg	2017	3,193	160	20	160		160	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)		$ 122,089	$ 1,855		$ 1,855	$	$ 80,989	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 122,089	$ 1,855		$ 1,855	$	$ 80,989	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 122,089	$ 1,855		$ 1,855	$	$ 80,989	34

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 83,739	$ 1,007	$ 8,838	$ 7,831	10	$ 67,001	71
72	Current Year Purchases	2,539		254	254	10	254	72
73	Fully Depreciated Assets	1,845,293				10	1,845,293	73
74								74
75	TOTALS	$ 1,931,571	$ 1,007	$ 9,092	$ 8,085		$ 1,912,548	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2007 PONTIAC VIBE - AUTO	2007	$ 17,535	$	$	$	5	$ 17,535	76
77		Allocated from Extended Care Consulting		7,976	225	225		5	7,751	77
78										78
79										79
80	TOTALS			$ 25,511	$ 225	$ 225	$		$ 25,286	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)	$ 11,020,409	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 250,887	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 292,749	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 41,862	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,552,676	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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				1,546			5
6								6
7	TOTAL				$ 1,546 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,364 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 # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/17 Ending: 12/31/17

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):									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.

STATE OF ILLINOIS

Facility Name & ID Number Grasmere Place **#** 0054213 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 33,571	$ 197,621	1
2	Cash-Patient Deposits	37,170	37,170	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	90,797	90,797	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,383	62,314	6
7	Other Prepaid Expenses	8,228	8,228	7
8	Accounts Receivable (owners or related parties)	251,283	251,283	8
9	Other(specify): See Attached Schedule		837,857	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 470,432	$ 1,485,270	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	1,134,672	2,073,015	15
16	Equipment, at Historical Cost	304,708	1,962,443	16
17	Accumulated Depreciation (book methods)	(1,128,524)	(6,282,574)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		802,278	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 310,856	$ 4,933,162	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 781,288	$ 6,418,432	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 212,671	$ 212,671	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,561	37,561	28
29	Short-Term Notes Payable	584,146	817,967	29
30	Accrued Salaries Payable	287,759	287,759	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,406	10,406	31
32	Accrued Real Estate Taxes(Sch.IX-B)		274,506	32
33	Accrued Interest Payable		26,650	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,132,543	$ 1,667,520	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,290,870	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)**	$	$ 7,290,870	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,132,543	$ 8,958,390	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (351,255)	$ (2,539,958)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 781,288	$ 6,418,432	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (255,581)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (255,581)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(95,674)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (95,674)	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)**	$ (351,255)	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	$ 6,855,481	1
2	Discounts and Allowances for all Levels	(3,511)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,851,970	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	3,511	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)**	$ 3,511	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,938	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,938	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,864,419	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,548,402	31
32	Health Care	2,466,437	32
33	General Administration	1,860,084	33
	B. Capital Expense		
34	Ownership	1,085,170	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)***	$ 6,960,093	40
41	**Income before Income Taxes (line 30 minus line 40)****	(95,674)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (95,674)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,807,460	44
45	Private Pay - Net Inpatient Revenue	44,510	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)	$ 6,851,970	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,926	2,150	$ 84,523	$ 39.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,788	2,021	76,828	38.01	3
4	Licensed Practical Nurses	17,912	19,793	519,059	26.22	4
5	CNAs & Orderlies	51,900	58,359	700,617	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,926	2,240	62,841	28.05	9
10	Activity Assistants	8,069	9,156	100,313	10.96	10
11	Social Service Workers	30,346	34,340	732,549	21.33	11
12	Dietician					12
13	Food Service Supervisor	2,012	2,302	42,792	18.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,841	5,544	74,663	13.47	15
16	Dishwashers	12,718	14,665	169,229	11.54	16
17	Maintenance Workers	12,510	13,789	187,888	13.63	17
18	Housekeepers	22,757	25,251	293,603	11.63	18
19	Laundry					19
20	Administrator	1,981	2,192	104,233	47.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,749	12,370	189,884	15.35	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	1,821	2,075	24,565	11.84	31
32	Other Health Care(specify)					32
33	Other(specify)	7,791	7,792	83,683	10.74	33
34	TOTAL (lines 1 - 33)	191,047	214,039	$ 3,447,270 *	$ 16.11	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,346	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	14	2,660	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	3,600	10-03	47
48					48
49	TOTAL (lines 35 - 48)	14	$ 14,206		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laura Feliciano-Dixon	Administrator	0	$ 104,233
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,233

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	$ 24,014
Personnel Planners, Inc.	Unemployment Consultant	1,968
ProPay	Payroll Service	29,208
Matrixcare	Billing Software	19,803
National Datacare Corporation	Resident Fund Processing	3,394
Extended Care Consulting	Home Office Expense	316,872
Various - See Attached	Legal	4,777
Blymas, Inc.	Tax Consulting	1,699
Legat Architects	Architect	945
Pinnacle Quality Insight	Consumer Review Analysis	604
Admiral Environmental Services	Environmental Compliance	369
See Supplemental Schedule		4,622
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 408,275

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,417
Unemployment Compensation Insurance	21,762
FICA Taxes	254,757
Employee Health Insurance	269,040
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	365
Pension Expense	24,431
Other Employee Welfare	2,857
Holiday Expense	2,428
TOTAL (agree to Schedule V, line 22, col.8)	$ 662,057

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,161
Advertising: Employee Recruitment	7,404
Health Care Worker Background Check	
(Indicate # of checks performed 1275)	6,385
Patient Background Checks	
Dues & Subscriptions	25,573
Licenses & Fees	1,434
Allocated from Extended Care Consulting	1,079
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,036

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,894
Allocated from Extended Care Consulting	46
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,940

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Grasmere Place # 0054213 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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?

(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. $ **299** 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.

(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.

(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. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% line 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