FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(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: 01/01/18 Ending: 12/31/18

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	63,696	487		64,183	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,696	487		64,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.41%

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	275,325	45,436		320,761		320,761	249	321,010			1
2	Food Purchase		336,211		336,211		336,211	480	336,691			2
3	Housekeeping	339,999	55,644		395,643		395,643	1,353	396,996			3
4	Laundry		1,527	44,080	45,607		45,607		45,607			4
5	Heat and Other Utilities			168,380	168,380		168,380	2,022	170,402			5
6	Maintenance	155,816		118,392	274,208		274,208	11,098	285,306			6
7	Other (specify):*							1,132	1,132			7
8	**TOTAL General Services**	771,140	438,818	330,852	1,540,810		1,540,810	16,334	1,557,144			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,419,132	34,142	24,908	1,478,182		1,478,182	(3,011)	1,475,171			10
10a	Therapy											10a
11	Activities	229,545	35,041		264,586		264,586		264,586			11
12	Social Services	652,526	9,215	1,710	663,451		663,451		663,451			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,301,203	78,398	30,218	2,409,819		2,409,819	(3,011)	2,406,808			16
	C. General Administration											
17	Administrative	104,848			104,848		104,848	24,214	129,062			17
18	Directors Fees											18
19	Professional Services			431,748	431,748	(12,365)	419,383	(310,051)	109,333			19
20	Dues, Fees, Subscriptions & Promotions			100,993	100,993		100,993	(49,845)	51,148			20
21	Clerical & General Office Expenses	197,262	18,455	61,048	276,765		276,765	153,523	430,288			21
22	Employee Benefits & Payroll Taxes			616,339	616,339		616,339	(8,151)	608,188			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,427	2,427		2,427	472	2,899			24
25	Other Admin. Staff Transportation			3,467	3,467		3,467	1,249	4,716			25
26	Insurance-Prop.Liab.Malpractice			374,296	374,296		374,296	17,802	392,098			26
27	Other (specify):*							38,381	38,381			27
28	**TOTAL General Administration**	302,110	18,455	1,590,318	1,910,883	(12,365)	1,898,518	(132,406)	1,766,113			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,374,453	535,671	1,951,388	5,861,512	(12,365)	5,849,147	(119,082)	5,730,065			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: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			67,622	67,622		67,622	237,559	305,181			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8	8		8	323,520	323,528			32
33	Real Estate Taxes			(36)	(36)	12,365	12,329	324,715	337,044			33
34	Rent-Facility & Grounds			1,035,040	1,035,040		1,035,040	(1,035,040)				34
35	Rent-Equipment & Vehicles			7,073	7,073		7,073	622	7,695			35
36	Other (specify):*							40,694	40,694			36
37	**TOTAL Ownership**			1,109,707	1,109,707	12,365	1,122,072	(107,930)	1,014,142			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)**	3,374,453	535,671	3,061,095	6,971,219		6,971,219	(227,012)	6,744,207			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: 01/01/18 Ending: 12/31/18

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	(17,364)	30		9
10	Interest and Other Investment Income	(18,923)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(26)	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	(2,805)	21		18
19	Entertainment				19
20	Contributions	(29,400)	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				24
25	Fund Raising, Advertising and Promotional	(7,790)	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	(47,480)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (123,788)		$	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)	(103,225)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (103,225)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (227,013)		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: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft Loss	$ (53)	21	1
2	Collection Expense	(2,244)	21	2
3	Jury Duty Income	(17)	10	3
4	Alliance for Living - Lobbying	(15,142)	20	4
5	Non Allowable Legal	(255)	19	5
6	Building Company - Management Feees	(10,050)	21	6
7	Building Company - Audit Fee	(10,500)	19	7
8	Building Company - Filing Fee	(75)	21	8
9	Building Company - Amortization	(2,990)	36	9
10	Building Company - State Replacement Tax	(400)	21	10
11	Capitalized R&M	(5,754)	06	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(47,480)		49

Grasmere Place

ID# 0054213

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			249									249	1
2	Food Purchase	(26)		506									480	2
3	Housekeeping			1,353									1,353	3
4	Laundry													4
5	Heat and Other Utilities			2,022									2,022	5
6	Maintenance	(5,754)		5,414	11,438								11,098	6
7	Other (specify):*				1,132								1,132	7
8	**TOTAL General Services**	(5,780)		9,544	12,570								16,334	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)				(2,994)							(3,011)	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**	(17)				(2,994)							(3,011)	16
	C. General Administration													
17	Administrative			1,940	22,274								24,214	17
18	Directors Fees													18
19	Professional Services	(10,755)	10,500	(309,796)									(310,051)	19
20	Fees, Subscriptions & Promotions	(52,332)		2,487									(49,845)	20
21	Clerical & General Office Expenses	(15,627)	10,525	12,762	145,863								153,523	21
22	Employee Benefits & Payroll Taxes				(8,151)								(8,151)	22
23	Inservice Training & Education													23
24	Travel and Seminar			472									472	24
25	Other Admin. Staff Transportation			1,249									1,249	25
26	Insurance-Prop.Liab.Malpractice		15,530	2,272									17,802	26
27	Other (specify):*				38,381								38,381	27
28	**TOTAL General Administration**	(78,714)	36,555	(288,614)	198,367								(132,406)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,511)	36,555	(279,070)	210,937	(2,994)							(119,082)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grasmere Place **#** 0054213 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(17,364)	251,620	3,303									237,559	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(18,923)	314,117	28,326									323,520	32
33	Real Estate Taxes		318,736	5,979									324,715	33
34	Rent-Facility & Grounds		(1,035,040)										(1,035,040)	34
35	Rent-Equipment & Vehicles			622									622	35
36	Other (specify):*	(2,990)	43,684										40,694	36
37	**TOTAL Ownership**	(39,277)	(106,883)	38,230									(107,930)	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)**	(123,788)	(70,328)	(240,840)	210,937	(2,994)							(227,012)	45

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,035,040	Grasmere Real Estate, LLC		$	$ (1,035,040)	1
2	V	32	Interest	334	Grasmere Real Estate, LLC		314,451	314,117	2
3	V	21	Management Fees		Grasmere Real Estate, LLC		10,050	10,050	3
4	V	19	Audit Fee		Grasmere Real Estate, LLC		10,500	10,500	4
5	V	36	Mortgage Insurance		Grasmere Real Estate, LLC		40,694	40,694	5
6	V	21	Filing Fees		Grasmere Real Estate, LLC		75	75	6
7	V	30	Depreciation		Grasmere Real Estate, LLC		251,620	251,620	7
8	V	36	Amortization		Grasmere Real Estate, LLC		2,990	2,990	8
9	V	33	Real Estate Tax		Grasmere Real Estate, LLC		318,736	318,736	9
10	V	21	State Replacement Tax		Grasmere Real Estate, LLC		400	400	10
11	V	26	Insurance		Grasmere Real Estate, LLC		15,530	15,530	11
12	V				Grasmere Real Estate, LLC				12
13	V								13
14	Total			$ 1,035,374			$ 965,046	$ * (70,328)	14

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 249	$ 249	15
16	V	02	Food		Extended Care Consulting, LLC		506	506	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,353	1,353	17
18	V	05	Utilities		Extended Care Consulting, LLC		2,022	2,022	18
19	V	06	Maintenance		Extended Care Consulting, LLC		5,414	5,414	19
20	V	17	Administrative		Extended Care Consulting, LLC		1,940	1,940	20
21	V	19	Professional Fees	316,872	Extended Care Consulting, LLC		7,076	(309,796)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,487	2,487	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		12,762	12,762	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		472	472	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		1,249	1,249	25
26	V	26	Insurance		Extended Care Consulting, LLC		2,272	2,272	26
27	V	30	Depreciation		Extended Care Consulting, LLC		3,303	3,303	27
28	V	32	Interest		Extended Care Consulting, LLC		28,326	28,326	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		5,979	5,979	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		622	622	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			$ 76,032	$ * (240,840)	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		11,438	$ 11,438	15
16	V	06	Maintenance (Direct)	1,760	Extended Care Consulting, LLC		1,760		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC		992	992	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC		140	140	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC		22,274	22,274	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC		145,863	145,863	22
23	V	21	Office and Clerical (Direct)	25,411	Extended Care Consulting, LLC		25,411		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC		33,623	33,623	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC		4,758	4,758	25
26	V	22	Employee Benefits	8,151	Extended Care Consulting, LLC			(8,151)	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			$ 35,322			$ 246,259	$ * 210,937	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	34,734	MAC Rx, LLC		31,741	(2,994)	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			$ 34,734			$ 31,741	$ * (2,994)	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 235,352	$ 235,352	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	235,352	CCS Employee Benefits Group			(235,352)	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			$ 235,352			$ 235,352	$ *	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	RACHEL ROTHNER ACCUM TRUST	4.86%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	MELISSA ROTHNER ACCUM TRUST	4.86%	GRASMERE PLACE, LLC	CHICAGO	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				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%	MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				12
13	WILLIAM ROTHNER	1.85%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14	DANIEL ROTHNER	1.85%	NAPERVILLE MANOR HEALTH & REHAB CENTER	NAPERVILLE				14
15	RACHEL ROTHNER	1.85%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16	MELISSA ROTHNER	1.85%	PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17	ADAM VALES	1.85%	RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18	KATHRYN SILVERS	1.85%	RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19	KIMBERLY RUDOLPH	1.85%	SHEFFIELD MANOR	DYER, IN				19
20	N. & S. ROTHNER FAMILY TRUST	46.99%	SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				20
21			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			SPRING CREEK NURSING & REHAB CENTER	JOLIET				23
24			ST. JAMES WELLNESS REHAB VILLAS	CRETE				24
25			THE ESTATES OF HYDE PARK	CHICAGO				25
26			THE PARC AT JOLIET	JOLIET				26
27			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				27
28			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				28
29								29
30								30

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	1.27	2.31%	Alloc Sal/Fee	$ 1,940	17-7	1
2	Adam Vales	Relative	Clerical	0	See Attached	1.12	2.79%	Alloc Salary	2,117	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	$ 4,057		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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	1,389,746	40	$ 5,386	$	64,183	$ 249	1
2	02	Food	Patient Days	1,389,746	40	10,961		64,183	506	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295		64,183	1,353	3
4	05	Utilities	Patient Days	1,389,746	40	43,781		64,183	2,022	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234		64,183	5,414	5
6	17	Administrative	Patient Days	1,389,746	40	42,000		64,183	1,940	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207		64,183	7,076	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847		64,183	2,487	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330		64,183	12,762	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217		64,183	472	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054		64,183	1,249	11
12	26	Insurance	Patient Days	1,389,746	40	49,193		64,183	2,272	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516		64,183	3,303	13
14	32	Interest	Patient Days	1,389,746	40	613,328		64,183	28,326	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471		64,183	5,979	15
16	35	Rent - Equipment	Patient Days	1,389,746	40	13,470		64,183	622	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,646,291	$		$ 76,032	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,389,746	40	247,664	247,664	64,183	11,438	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298		1,760	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		64,183	992	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140			140	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	64,183	22,274	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	64,183	145,863	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472		25,411	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		64,183	33,623	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742			4,758	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					$ 5,599,498	$ 4,730,091		$ 246,259	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation						31,741	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					$	$		$ 31,741	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 235,352	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					$	$		$ 235,352	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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			$	$ 7,290,870			$ 314,451	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Daiwa		X	Line of Credit				392,525			8	6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,683,395			$ 314,459	9
	B. Non-Facility Related*											
10	Interest Income		X								(18,923)	10
11	Interest Income (Bldg Co)										(334)	11
12	Alloc from Extended Care Consulting										28,326	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,069	14
15	TOTALS (line 9+line14)						$	$ 7,683,395			$ 323,528	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 40,694 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: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	274,506	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.)	$	287,543	2
3. Under or (over) accrual (line 2 minus line 1).	$	13,037	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	311,642	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.)**	$	12,365	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** $ 904 **For** 13-15 **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.	$	337,043	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	204,166	8
2014	207,194	9
2015	227,943	10
2016	261,435	11
2017	281,564	12

2018 Accrual = 281,564 x 1.05 = 295,642 + 16,000 = $311,642

Allocated from Extended Care Consulting $5,979

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054213

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

	(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	$ 252,144.89	$ 252,144.89
2.	14-17-214-002-0000	Long Term Care Property	$ 14,716.48	$ 14,716.48
3.	14-17-214-003-0000	Long Term Care Property	$ 14,702.46	$ 14,702.46
4.	See Attached	Allocated from Care Center Bldg	$ 190,923.89	$ 5,979.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 472,487.72	$ 287,542.83

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054213

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 800,000	1
2	Allocated from Care Center Building			25,681	2
3	TOTALS			$ 825,681	3

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 251,620	35	$ 159,371	$ (92,249)	$ 3,173,739	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	83,114		20	3,790	3,790	73,021	9
10	Various			2000	251,874		20	12,463	12,463	235,455	10
11	Various			2001	59,759		20	2,988	2,988	52,713	11
12	Various			2002	147,991		20	700	700	145,273	12
13	Various			2003	29,651		20	1,483	1,483	23,297	13
14	Various			2004	70,279		20	170	170	69,297	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	1,219	1,219	13,572	17
18	Various			2009	24,708		20	2,471	2,471	22,922	18
19	Various			2010	2,584		20			2,584	19
20	Various			2011	72,172		20	3,916	3,916	41,715	20
21	Various			2012	141,113		20	5,049	5,049	116,133	21
22	Various			2013	76,841		20	5,120	5,120	35,813	22
23	Various			2014	12,596		20	755	755	3,314	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: 01/01/18 Ending: 12/31/18

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			62,493	62,493	704,145	67
68	Related Party Allocations (Pages 12H & 12I)		129,107	2,015		2,015		86,673	68
69	Financial Statement Depreciation			67,622			(67,622)		69
70	TOTAL (lines 4 thru 69)		$ 7,990,452	$ 321,257		$ 264,002	$ (57,255)	$ 4,867,946	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: 01/01/18 Ending: 12/31/18

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		$ 7,990,452	$ 321,257		$ 264,002	$ (57,255)	$ 4,867,946	1
2	Repair Entrance Gate	2015	3,804		20	254	254	1,014	2
3	Replace Water Heater	2015	9,547		20	477	477	1,870	3
4	2 New Doors In Kitchen	2015	5,300		20	265	265	1,016	4
5	New Vestibule Entry	2015	5,750		20	288	288	1,126	5
6	Main Sewer Repairs	2015	17,950		20	898	898	3,066	6
7	Rodding Main Sewer	2015	8,950		20	448	448	1,566	7
8	Curtains	2015	2,654		20	133	133	420	8
9	Boiler Repairs	2015	6,824		20	341	341	1,080	9
10	New Flanges, Gaskets And Pump	2015	2,512		20	126	126	387	10
11	Walk-In Cooler - Replace Compressor & Drier, Wire In New Com	2015	2,677		20	134	134	524	11
12	Elevator Repair - Install Gate Restrictor, Door Lock Cover	2015	5,448		20	272	272	840	12
13	Gate, Lock And Hand Rails	2016	5,200		20	260	260	672	13
14	Lower Roof Repairs - Remove Curbs / Hvac / Insulation	2016	6,800		20	340	340	878	14
15	Main Roof Repair - Caulk / Coping Metal / Pipes	2016	6,950		20	348	348	898	15
16	Demo Pipe, Light Fixtures, Gfi Receptacle	2016	4,120		20	206	206	515	16
17	Ansul System Switch & Fire Alarm System Device	2016	3,676		20	184	184	460	17
18	Lower Roof Repair - Metal Coping / Coating	2016	5,525		20	276	276	622	18
19	Upper Roof Repair - Repaired Walls	2016	3,400		20	170	170	383	19
20	Plumbing Repairs - Workshop Room, Rear Of Kitchen	2017	12,900		20	645	645	1,075	20
21	Hvac - Condensate Return Tank Pump	2017	3,463		20	173	173	289	21
22	Fire Alarm System Modifications	2017	33,967		20	1,698	1,698	2,548	22
23	Walk In Cooler Repair	2017	3,831		20	192	192	303	23
24	A/C Unit Repair - New Blades & Motor	2017	4,034		20	202	202	286	24
25	Walk In Freezer - Upgrade Refrigeration System	2017	7,642		20	382	382	509	25
26	3Rd Floor Remodeling - Wall Replacement & Paint	2017	16,350		20	818	818	886	26
27	3Rd Floor Remodeling - Wall Replacement & Paint	2017	19,850		20	993	993	1,075	27
28	3Rd Floor Remodeling - Wall Replacement & Paint	2017	19,879		20	994	994	1,077	28
29	3Rd Floor Remodeling - Wall Replacement & Paint	2017	18,815		20	941	941	1,019	29
30	Plumbing Repairs	2017	7,500		20	375	375	406	30
31	Plumbing Repairs	2018	5,500		20	275	275	275	31
32	New Steel Metal Fence	2018	9,400		20	431	431	431	32
33	Plumbing Repairs 1St & 2Nd Floor	2018	7,000		20	263	263	263	33
34	TOTAL (lines 1 thru 33)		$ 8,267,669	$ 321,257		$ 277,800	$ (43,457)	$ 4,895,723	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: 01/01/18 Ending: 12/31/18

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		$ 8,267,669	$ 321,257		$ 277,800	$ (43,457)	$ 4,895,723	1
2	10 Wall Air Conditioners	2018	4,423		20	184	184	184	2
3	Electrical Work Throughout Building	2018	24,000		20	400	400	400	3
4	3Rd Floor Remodeling - Wall Replacement & Painting	2018	374,742		20	15,644	15,644	15,644	4
5	2Nd Floor Wall Replacement & Painting	2018	457,836		20	1,526	1,526	1,526	5
6	1St, 2Nd, 3Rd Floor Thermostat Installation	2018	2,819		20	141	141	282	6
7	Installed Ac Units	2018	2,935		20	147	147	147	7
8	Boiler - New Tubes	2018	18,037		20	902	902	902	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,152,461	$ 321,257		$ 296,743	$ (24,514)	$ 4,914,808	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: 01/01/18 Ending: 12/31/18

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		$ 9,152,461	$ 321,257		$ 296,743	$ (24,514)	$ 4,914,808	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,152,461	$ 321,257		$ 296,743	$ (24,514)	$ 4,914,808	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: 01/01/18 Ending: 12/31/18

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		$ 9,152,461	$ 321,257		$ 296,743	$ (24,514)	$ 4,914,808	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
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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)		$ 9,152,461	$ 321,257		$ 296,743	$ (24,514)	$ 4,914,808	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: 01/01/18 Ending: 12/31/18

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	313,916	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	87,124	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	18,131	11
12	Grasmere Real Estate (various)	2005	98,203		20	4,910	4,910	70,846	12
13	Grasmere Real Estate (various)	2006	87,251		20	4,363	4,363	52,931	13
14	Grasmere Real Estate (various)	2007	14,669		20	733	733	8,796	14
15	Piping Repair	2008	7,309		20	365	365	4,015	15
16	Elevator Repair	2008	2,738		20	137	137	1,507	16
17	Boiler Repair	2008	9,826		20	491	491	5,401	17
18	Fire Escape Repairs	2009	9,160		20	458	458	4,580	18
19	Masonry Repairs	2009	2,810		20	141	141	1,410	19
20	USA Satellite & Cable	2009	4,810		20	281	281	3,610	20
21	Window Screen	2009	5,880		20	294	294	2,940	21
22	Boiler	2009	6,061		20	303	303	3,030	22
23	Masonry Repairs	2010	51,315		20	2,566	2,566	23,094	23
24	Replace Plumbing in rooms 204 & 208	2011	3,610		20	181	181	1,267	24
25	New Sprinkler Heads	2012	15,512		20	776	776	5,432	25
26	Replace Underground Steam Pipes	2012	13,950		20	698	698	4,886	26
27	Replace Kitchen Floor and Walls	2012	8,970		20	449	449	3,143	27
28	Remove and Replace Walls in Dishwasher Room	2012	3,420		20	171	171	1,197	28
29	Roofing Repairs	2012	3,596		20	180	180	1,260	29
30	Remove and Replace Chimney	2012	8,280		20	414	414	2,898	30
31	Replace Steel Doors, Flooring	2012	9,890		20	495	495	3,465	31
32	Replace Window Hardware	2012	9,532		20	477	477	3,339	32
33	New Window Screens	2012	2,610		20	131	131	917	33
34	TOTAL (lines 1 thru 33)		$ 815,879	$		$ 40,839	$ 40,839	$ 629,135	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 815,879	$		$ 40,839	$ 40,839	$ 629,135	1
2	Window Replacement Parts	2012	7,638		20	382	382	2,674	2
3	Install Mass Notification System & Wireless Nurse Call System	2013	67,027		20	3,351	3,351	20,106	3
4	South Side 2nd Floor and North Side 3rd Floor	2013	86,984		20	4,349	4,349	26,094	4
5	Exterior Steel Door Replacement	2017	3,800		20	190	190	380	5
6	Repair Brick & Tuckpoint on Back Wall of Building	2017	12,000		20	600	600	1,200	6
7	Kitchen Floor Tile Replacement	2017	15,000		20	750	750	1,500	7
8	Door/Hinge Replacement - 3rd Floor Stairwell & Northside Eastw	2017	4,601		20	230	230	460	8
9	Paint Exterior Wall & Ceiling on Back Side of Building	2017	10,000		20	500	500	1,000	9
10	Electrical Box Main Breaker Replacement	2017	7,000		20	350	350	700	10
11	Door Repairs-3rd Flr Stairwell, Activity Rm, Nurses Station, Mair	2017	5,000		20	250	250	500	11
12	3rd Floor - Remove Wallpaper, Patch Walls, Paint	2017	38,382		20	1,919	1,919	3,838	12
13	Tuckpoint Interior Courtyard Walls and Chimney	2017	155,500		20	7,775	7,775	15,550	13
14					20	1,008	1,008	1,008	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	$		$ 62,493	$	$ 704,145	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: 01/01/18 Ending: 12/31/18

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	35,389	907	35	907		14,783	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	11,084	246	35	246		2,823	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting-Care Center Bldg	2002	29,234		20			29,234	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2003	34,452		20			34,452	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,712		20			1,712	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2009	309	15	20	15		154	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,965	148	20	148		741	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2015	487	24	20	24		210	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,924	96	20	96		289	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,337	167	20	167		334	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,529	76	20	76		76	17
18	Allocated from Extended Care Consulting	2007	212	11	20	11		127	18
19	Allocated from Extended Care Consulting	2009	127	6	20	6		64	19
20	Allocated from Extended Care Consulting	2010	1,246	62	20	62		561	20
21	Allocated from Extended Care Consulting	2011	448	22	20	22		180	21
22	Allocated from Extended Care Consulting	2012	148	7	20	7		52	22
23	Allocated from Extended Care Consulting	2014	2,048	102	20	102		512	23
24	Allocated from Extended Care Consulting	2016	2,456	123	20	123		368	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)		$ 129,107	$ 2,015		$ 2,015	$	$ 86,673	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: 01/01/18 Ending: 12/31/18

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		$ 129,107	$ 2,015		$ 2,015	$	$ 86,673	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 129,107	$ 2,015		$ 2,015	$	$ 86,673	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: 01/01/18 Ending: 12/31/18

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	$ 83,507	$ 1,053	$ 8,202	$ 7,149	10	$ 72,405	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,854,569				10	1,854,569	73
74								74
75	TOTALS	$ 1,938,076	$ 1,053	$ 8,202	$ 7,149		$ 1,926,974	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2007 PONTIAC VIBE - AUTO	2007	$ 17,535	$	$	$	5	$ 17,535	76
77		Alloc. Extended Care Consulting	2014	1,176	235	235	0	5	1,176	77
78										78
79										79
80	TOTALS			$ 18,711	$ 235	$ 235	$ 0		$ 18,711	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)	$ 11,934,929	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 322,544	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 305,180	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,364)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,860,492	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: 01/01/18 Ending: 12/31/18

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								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 7,694 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: 01/01/18 Ending: 12/31/18

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									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: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 494,629	$ 683,905	1
2	Cash-Patient Deposits	35,983	35,983	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,219,970	1,219,970	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,620	58,612	6
7	Other Prepaid Expenses	4,406	4,406	7
8	Accounts Receivable (owners or related parties)	4,207	4,207	8
9	Other(specify): See Attached Schedule		282,147	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,804,815	$ 2,289,230	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	1,623,435	3,221,321	15
16	Equipment, at Historical Cost	309,131	1,966,866	16
17	Accumulated Depreciation (book methods)	(1,196,146)	(6,608,032)	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		799,288	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 736,420	$ 5,757,443	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,541,235	$ 8,046,673	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,284,986	$ 2,287,621	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,013	41,013	28
29	Short-Term Notes Payable	392,525	636,479	29
30	Accrued Salaries Payable	295,266	295,266	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,031	11,031	31
32	Accrued Real Estate Taxes(Sch.IX-B)		311,642	32
33	Accrued Interest Payable		25,822	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)**	$ 3,024,821	$ 3,608,874	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,046,916	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)**	$	$ 7,046,916	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,024,821	$ 10,655,790	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (483,586)	$ (2,609,117)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,541,235	$ 8,046,673	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (351,255)	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (351,258)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(132,328)	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)**	$ (132,328)	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)**	$ (483,586)	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	$ 6,954,190	1
2	Discounts and Allowances for all Levels	(167,713)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,786,477	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	5,124	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)**	$ 5,124	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,923	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,923	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	28,367	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,367	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,838,891	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,540,810	31
32	Health Care	2,409,819	32
33	General Administration	1,910,883	33
	B. Capital Expense		
34	Ownership	1,109,707	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)***	$ 6,971,219	40
41	**Income before Income Taxes (line 30 minus line 40)****	(132,328)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (132,328)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,721,638	44
45	Private Pay - Net Inpatient Revenue	64,839	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)	$ 6,786,477	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	1,910	2,054	$ 84,050	$ 40.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,799	2,159	83,188	38.53	3
4	Licensed Practical Nurses	16,462	18,375	493,776	26.87	4
5	CNAs & Orderlies	50,082	56,023	733,030	13.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,862	2,094	60,128	28.71	9
10	Activity Assistants	6,794	7,618	89,927	11.80	10
11	Social Service Workers	25,978	28,933	652,526	22.55	11
12	Dietician					12
13	Food Service Supervisor	2,248	2,524	47,921	18.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,352	4,899	69,359	14.16	15
16	Dishwashers	10,940	12,335	158,045	12.81	16
17	Maintenance Workers	9,551	10,570	155,816	14.74	17
18	Housekeepers	23,774	26,747	339,999	12.71	18
19	Laundry					19
20	Administrator	1,909	2,142	104,848	48.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,753	2,032	42,925	21.12	23
24	Clerical	8,835	9,999	154,337	15.44	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	1,857	2,084	25,088	12.04	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	7,226	7,226	79,490	11.00	33
34	TOTAL (lines 1 - 33)	177,332	197,814	$ 3,374,453 *	$ 17.06	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	21,608	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	9	1,710	12-03	45
46	Other(specify)				46
47	Phsychiatrist	Monthly	3,300	10-03	47
48					48
49	TOTAL (lines 35 - 48)	9	$ 30,218		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 C. Feliciano-Dixon	Administrator		$ 104,848
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,848

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	$ 23,925
Personnel Planners, Inc.	Unemployment Consultant	1,224
Various - See Attached	Legal	6,625
Extended Care Consulting	Home Office Expense	316,872
Blymas, INC.	Tax Consulting	1,764
Pinnacle Quality Insights	Consumer Review Analysis	604
MTS Consulting	WOTC Consultants	367
S4 Group	Government Relations	272
Kelleher & Assoc.	Management Consulting	728
Resolute Healthcare	Operations Consultants	4,125
Benefit Services Group	Benefits Administration	581
See Supplemental Schedule		74,661
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 431,748

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,895
Unemployment Compensation Insurance	23,191
FICA Taxes	249,431
Employee Health Insurance	232,873
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	91
Pension Expense	27,545
Other Employee Welfare	2,951
Holiday Expense	1,211
TOTAL (agree to Schedule V, line 22, col.8)	$ 608,188

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 829
Advertising: Employee Recruitment	18,348
Health Care Worker Background Check	
(Indicate # of checks performed 285)	
Patient Background Checks	7,531
Dues & Subscriptions	20,402
Licenses & Fees	1,551
Allocated from Extended Care Consulting	2,487
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,148

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,427
Allocated from Extended Care Consulting	472
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,899

**See instructions.

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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 $28,145**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.