		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 Road (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 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
* *Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	216	Intermediate (ICF)	216	79,056	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	79,056	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	56,896	366		57,262	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,896	366		57,262	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.43%

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 N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	339,958	42,040		381,998		381,998	187	382,185			1
2	Food Purchase		319,404		319,404		319,404	114	319,518			2
3	Housekeeping	381,192	43,958		425,150		425,150	1,630	426,780			3
4	Laundry		809	35,857	36,666		36,666		36,666			4
5	Heat and Other Utilities			174,754	174,754		174,754	(25,759)	148,995			5
6	Maintenance	189,366	119	147,525	337,010		337,010	19,427	356,437			6
7	Other (specify):*							4,913	4,913			7
8	TOTAL General Services	910,516	406,330	358,136	1,674,982		1,674,982	512	1,675,494			8
	B. Health Care and Programs											
9	Medical Director			6,300	6,300		6,300		6,300			9
10	Nursing and Medical Records	1,585,031	69,505	21,838	1,676,374		1,676,374	(2,523)	1,673,851			10
10a	Therapy											10a
11	Activities	218,097	11,473		229,570		229,570		229,570			11
12	Social Services	634,178	10,000		644,178		644,178		644,178			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,437,306	90,978	28,138	2,556,422		2,556,422	(2,523)	2,553,899			16
	C. General Administration											
17	Administrative	113,522			113,522		113,522	23,351	136,873			17
18	Directors Fees											18
19	Professional Services			431,380	431,380	(18)	431,362	(325,581)	105,781			19
20	Dues, Fees, Subscriptions & Promotions			110,333	110,333		110,333	(56,505)	53,828			20
21	Clerical & General Office Expenses	166,760	23,216	219,608	409,584		409,584	(1,999)	407,585			21
22	Employee Benefits & Payroll Taxes			609,731	609,731		609,731	(3,132)	606,599			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,330	1,330		1,330	496	1,826			24
25	Other Admin. Staff Transportation			344	344		344	935	1,279			25
26	Insurance-Prop.Liab.Malpractice			297,966	297,966		297,966	21,607	319,573			26
27	Other (specify):*							34,367	34,367			27
28	TOTAL General Administration	280,282	23,216	1,670,692	1,974,190	(18)	1,974,172	(306,461)	1,667,711			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,628,104	520,524	2,056,966	6,205,594	(18)	6,205,576	(308,472)	5,897,104			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: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			51,844	51,844		51,844	271,770	323,614			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							279,553	279,553			32
33	Real Estate Taxes			(42)	(42)	18	(24)	263,283	263,259			33
34	Rent-Facility & Grounds			1,068,000	1,068,000		1,068,000	(1,068,000)				34
35	Rent-Equipment & Vehicles			5,726	5,726		5,726	342	6,068			35
36	Other (specify):*							38,005	38,005			36
37	**TOTAL Ownership**			1,125,528	1,125,528	18	1,125,546	(215,047)	910,499			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)**	3,628,104	520,524	3,182,494	7,331,122		7,331,122	(523,519)	6,807,603			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: 01/01/20 Ending: 12/31/20

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 Reference	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	(27,545)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,298	30		9
10	Interest and Other Investment Income	(25,301)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(31,850)	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	(171,170)	21		24
25	Fund Raising, Advertising and Promotional	(3,158)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,012)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(61,789)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (283,549)		$	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)	(239,970)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (239,970)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (523,519)		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: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (184)	21	1
2	Collection Expense	(704)	21	2
3	Alliance for Living - Lobbying Expense	(17,532)	20	3
4	Non-Allowable Legal	(691)	19	4
5	Building Company - Management Fee	(10,050)	21	5
6	Building Company - Audit Fee	(11,900)	19	6
7	Building Company - Filing Fees	(75)	21	7
8	Building Company - Amortization	(2,990)	36	8
9	Building Company - State Replacement Tax	(1,000)	21	9
10	Real Estate Tax - Convenience Fee	(42)	21	10
11	Additional R&M	159	6	11
12	Capitalized R&M	(9,775)	6	12
13	Prior Year Dues	(7,005)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(61,789)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Gramercy Place

IDH 0054213
Report Period Beginning: 01/01/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			187									187	1
2	Food Purchase	(22)		136									114	2
3	Housekeeping			1,630									1,630	3
4	Laundry													4
5	Heat and Other Utilities	(27,545)		1,786									(25,759)	5
6	Maintenance	(9,616)		29,043									19,427	6
7	Other (specify):*			4,913									4,913	7
8	**TOTAL General Services**	(37,183)		37,695									512	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(2,523)								(2,523)	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**				(2,523)								(2,523)	16
	C. General Administration													
17	Administrative			23,351									23,351	17
18	Directors Fees													18
19	Professional Services	(12,591)	11,900	(324,890)									(325,581)	19
20	Fees, Subscriptions & Promotions	(59,545)		3,040									(56,505)	20
21	Clerical & General Office Expenses	(185,237)	11,125	172,113									(1,999)	21
22	Employee Benefits & Payroll Taxes			(3,132)									(3,132)	22
23	Inservice Training & Education													23
24	Travel and Seminar			496									496	24
25	Other Admin. Staff Transportation			935									935	25
26	Insurance-Prop.Liab.Malpractice		19,603	2,004									21,607	26
27	Other (specify):*			34,367									34,367	27
28	**TOTAL General Administration**	(257,373)	42,628	(91,716)									(306,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(294,556)	42,628	(54,021)	(2,523)								(308,472)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grasmere Place **#** 0054213 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	39,298	229,328	3,144									271,770	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,301)	293,618	11,236									279,553	32
33	Real Estate Taxes		257,029	6,254									263,283	33
34	Rent-Facility & Grounds		(1,068,000)										(1,068,000)	34
35	Rent-Equipment & Vehicles			342									342	35
36	Other (specify):*	(2,990)	40,995										38,005	36
37	**TOTAL Ownership**	11,007	(247,030)	20,976									(215,047)	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)**	(283,549)	(204,402)	(33,045)	(2,523)								(523,519)	45

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 1,068,000	Grasmere Real Estate, LLC		$	$ (1,068,000)	1
2	V	32	Interest	55	Grasmere Real Estate, LLC		293,673	293,618	2
3	V	21	Management Fees		Grasmere Real Estate, LLC		10,050	10,050	3
4	V	19	Audit Fee		Grasmere Real Estate, LLC		11,900	11,900	4
5	V	21	Filing Fees		Grasmere Real Estate, LLC		75	75	5
6	V	30	Depreciaiton		Grasmere Real Estate, LLC		229,328	229,328	6
7	V	36	Amortization		Grasmere Real Estate, LLC		2,990	2,990	7
8	V	33	Real Estate Tax		Grasmere Real Estate, LLC		257,029	257,029	8
9	V	21	State Replacement Tax		Grasmere Real Estate, LLC		1,000	1,000	9
10	V	26	Insurance		Grasmere Real Estate, LLC		19,603	19,603	10
11	V	36	Mortgage Insurance Premium		Grasmere Real Estate, LLC		38,005	38,005	11
12	V								12
13	V								13
14	Total			$ 1,068,055			$ 863,653	$ * (204,402)	14

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	WILLIAM ROTHNER ACCUM. TRUST	4.86%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	GRASMERE REAL ESTATE, LLC	CHICAGO	BUILDING COMPANY	1
2	DANIEL ROTHNER ACCUM TRUST	4.86%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTIN	EVANSTON	MGMT/BOOKKEEPING	2
3	RACHEL ROTHNER ACCUM TRUST	4.86%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	MELISSA ROTHNER ACCUM TRUST	4.86%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	ADAM VALES ACCUM TRUST	4.86%	ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	KATHRYN VALES ACCUM TRUST	4.86%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	KIMBERLY VALES ACCUM TRUST	4.86%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8	NEAL & BEATA ROTHNER	.69%	MAJOR HOSPITAL DYER	DYER, IN				8
9	DR. DAVID & SARA ROTHNER	.69%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10	LINDA VARDI	.69%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11	SANDRA & HILLEL KLIERS	.69%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12	NATHAN & SHIRLEY GRANDCHILDREN TRUST	3.24%	MAJOR HOSPITAL SEBOS	HOBART, IN				12
13	WILLIAM ROTHNER	1.85%	MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				13
14	DANIEL ROTHNER	1.85%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				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%	SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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		$ 187	$ 187	15
16	V	02	Food		Extended Care Consulting, LLC		136	136	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,630	1,630	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,786	1,786	18
19	V	06	Maintenance		Extended Care Consulting, LLC		3,557	3,557	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	332,160	Extended Care Consulting, LLC		7,270	(324,890)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		3,040	3,040	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		16,010	16,010	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		496	496	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		935	935	25
26	V	26	Insurance		Extended Care Consulting, LLC		2,004	2,004	26
27	V	30	Depreciation		Extended Care Consulting, LLC		3,144	3,144	27
28	V	32	Interest		Extended Care Consulting, LLC		11,236	11,236	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		6,254	6,254	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		342	342	30
31	V	06	Maintenance Salaries	1,451	Extended Care Consulting, LLC		26,937	25,486	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		4,913	4,913	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		23,351	23,351	33
34	V	21	Office and Clerical Salaries	8,987	Extended Care Consulting, LLC		165,090	156,103	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		34,367	34,367	35
36	V	22	Employee Benefits	3,132	Extended Care Consulting, LLC			(3,132)	36
37	V								37
38	V								38
39	Total			$ 345,730			$ 312,685	$ * (33,045)	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 31,633	MAC Rx, LLC		$ 28,677	$ (2,523)	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			$ 31,633			$ 28,677	$ * (2,523)	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 174,278	$ 174,278	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	174,278	CCS Employee Benefits Group			(174,278)	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			$ 174,278			$ 174,278	$ *	39

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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	Adam Vales	Relative	Clerical	0	See Attached	0.87	2.17%	Alloc Salary	$ 1,549	22-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,549		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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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	1,219,947	38	$ 3,992	$	57,066	$ 187	1
2	02	Food	Patient Days	1,219,947	38	2,910		57,066	136	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		57,066	1,630	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		57,066	1,786	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		57,066	3,557	5
6	17	Administrative	Patient Days	1,219,947	38			57,066		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		57,066	7,270	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		57,066	3,040	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		57,066	16,010	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		57,066	496	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		57,066	935	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		57,066	2,004	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		57,066	3,144	13
14	32	Interest	Patient Days	1,219,947	38	240,208		57,066	11,236	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		57,066	6,254	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		57,066	342	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	57,066	26,937	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		57,066	4,913	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	57,066	23,351	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	57,066	165,090	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		57,066	34,367	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 312,685	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 28,677	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					$	$		$ 28,677	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 174,278	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					$	$		$ 174,278	25

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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
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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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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
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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: 01/01/20 Ending: 12/31/20

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
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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: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 6,792,390			$ 293,673	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,792,390			$ 293,673	9
	B. Non-Facility Related*											
10	Interest Income		X								(25,301)	10
11	Interest Income - Bldg Co.		X								(55)	11
12	Alloc from Extended Care Consulting										11,236	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,120)	14
15	TOTALS (line 9+line14)						$	$ 6,792,390			$ 279,553	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 38,005 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: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 260,615	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.)		$ 258,743	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,872)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 265,113	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.)		$ 18	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 263,259	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	227,943	8
	2016	261,435	9
	2017	281,564	10
	2018	248,204	11
	2019	252,489	12

2020 Accrual = $252,489 x 1.05 = $265,113

Allocated from Extended Care Consulting $6,254

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054213

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 220,855.60	$ 220,855.60
2.	14-17-214-002-0000	Long Term Care Property	$ 15,821.23	$ 15,821.23
3.	14-17-214-003-0000	Long Term Care Property	$ 15,812.00	$ 15,812.00
4.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 6,254.20
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 449,651.52	$ 258,743.03

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054213

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			26,011	2
3	TOTALS			$ 826,011	3

Facility Name & ID Number Grasmere Place # 0054213 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 229,328	35	$ 159,371	$ (69,957)	$ 3,492,481	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	83,114		20	755	755	76,572	9
10	Various			2000	251,874		20	4,181	4,181	251,874	10
11	Various			2001	59,759		20	2,940	2,940	58,524	11
12	Various			2002	147,991		20	701	701	146,675	12
13	Various			2003	29,651		20	1,483	1,483	26,265	13
14	Various			2004	70,280		20	170	170	69,718	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			13,572	17
18	Various			2009	24,708		20			24,708	18
19	Various			2010	2,584		20			2,584	19
20	Various			2011	72,172		20	2,986	2,986	48,505	20
21	Various			2012	141,114		20	2,915	2,915	124,098	21
22	Various			2013	76,841		20	3,502	3,502	44,436	22
23	Various			2014	12,596		20	630	630	4,699	23
24	Various			2015	71,416		20	3,572	3,572	20,118	24
25	Various			2016	35,671		20	1,784	1,784	7,994	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: 01/01/20 Ending: 12/31/20

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			46,391	46,391	783,874	67
68	Related Party Allocations (Pages 12H & 12I)		131,508	2,078		2,078		91,993	68
69	Financial Statement Depreciation			51,844			(51,844)		69
70	TOTAL (lines 4 thru 69)		$ 8,099,942	$ 283,250		$ 233,459	$ (49,791)	$ 5,356,970	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: 01/01/20 Ending: 12/31/20

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		$ 8,099,942	$ 283,250		$ 233,459	$ (49,791)	$ 5,356,970	1
2	Plumbing Repairs - Workshop Room, Rear Of Kitchen	2017	12,900		20	645	645	2,365	2
3	Hvac - Condensate Return Tank Pump	2017	3,463		20	173	173	635	3
4	Fire Alarm System Modifications	2017	33,967		20	1,698	1,698	5,944	4
5	Walk In Cooler Repair	2017	3,831		20	192	192	687	5
6	A/C Unit Repair - New Blades & Motor	2017	4,034		20	202	202	689	6
7	Walk In Freezer - Upgrade Refrigeration System	2017	7,642		20	382	382	1,274	7
8	Plumbing Repairs	2017	7,500		20	375	375	1,156	8
9	3Rd Floor Remodeling - Wall Replacement & Paint	2017	16,350		20	818	818	2,521	9
10	3Rd Floor Remodeling - Wall Replacement & Paint	2017	19,850		20	993	993	3,061	10
11	3Rd Floor Remodeling - Wall Replacement & Paint	2017	19,879		20	994	994	3,065	11
12	3Rd Floor Remodeling - Wall Replacement & Paint	2017	18,815		20	941	941	2,901	12
13	New Steel Metal Fence	2018	9,400		20	470	470	1,671	13
14	10 Wall Air Conditioners	2018	4,423		20	221	221	534	14
15	Electrical Work Throughout Facility	2018	24,000		20	1,200	1,200	2,800	15
16	Boiler - New Tubes	2018	18,037		20	902	902	1,954	16
17	Plumbing Repairs	2018	5,500		20	275	275	825	17
18	Plumbing Repairs	2018	7,000		20	350	350	963	18
19	1St, 2Nd, 3Rd Floor Thermostat Installation	2018	2,819		20	141	141	399	19
20	Installed A/C Units	2018	2,935		20	147	147	379	20
21	3Rd Floor Remodeling - Wall Replacement & Paint	2018	374,742		20	18,737	18,737	51,527	21
22	2Nd Floor Wall Replacement & Paint	2018	437,066		20	21,853	21,853	52,375	22
23	Boiler Room Repair And Addition	2019	5,206		20	260	260	520	23
24	3Rd Floor Phone Line Replacement	2019	3,239		20	162	162	297	24
25	Boiler Repairs	2019	5,592		20	280	280	513	25
26	Steam Leak	2019	2,767		20	138	138	253	26
27	5 - 1/2' Rpz'S On Chemical Feeders	2019	6,900		20	345	345	690	27
28	Nurse Call System	2019	13,740		20	687	687	1,260	28
29	Floor Demolition In Kitchen & Dining Rm Area	2019	8,701		20	435	435	689	29
30	Gravel/Concrete Install In Kitchen & Dining Rm Area	2019	11,354		20	568	568	899	30
31	Kitchen & Dining Rm-Plumbing, Vct Tile Floor, Trim & Doors In	2019	16,938		20	847	847	1,341	31
32	Electrical Panel Replacement/Ac Replacement In Kitchen	2019	15,175		20	759	759	1,012	32
33	1St Flr Wall Replacement & Painting - Rooms,Bathrooms,Hallwa	2019	482,471		20	24,124	24,124	47,831	33
34	TOTAL (lines 1 thru 33)		$ 9,706,178	$ 283,250		$ 313,773	$ 30,523	$ 5,550,000	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: 01/01/20 Ending: 12/31/20

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		$ 9,706,178	$ 283,250		$ 313,773	$ 30,523	$ 5,550,000	1
2	Ac Unit Replacement Room 240 & 242	2019	5,180		20	259	259	518	2
3	Dietary Rm Walk In Fridge - Compressor Repair	2019	2,845		20	142	142	284	3
4	Passenger Elevator Repair - Trace Wiring And Shorts	2019	3,354		20	168	168	336	4
5	Wall Replacement & Paint (South 1St Flr/Kitchen/Stairwell/Rm 1	2020	63,483		20	3,174	3,174	3,174	5
6	A/C Wall Unit Replacement Room 223	2020	2,880		20	144	144	144	6
7	Three 119 Gallon Storage Tanks Piped In Parallel	2020	19,800		20	990	990	990	7
8	7 A/C Wall Units	2020	2,843		20	142	142	142	8
9	A/C Wall Unit Replacements Rooms 319, 340, 342	2020	9,694		20	485	485	485	9
10	A/C Wall Unit Replacements Rooms 348,325,245,248,323,221,138	2020	22,430		20	1,122	1,122	1,122	10
11	Building Brick Repairs	2020	11,983		20	599	599	599	11
12	Electrical - Install New 220 Outlet For Washer	2020	2,850		20	143	143	143	12
13	Boiler Repair - Replace Head Assembly	2020	4,166		20	208	208	208	13
14	Brick Repair On Back Of Building	2020	2,759		20	138	138	138	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)		$ 9,860,445	$ 283,250		$ 321,486	$ 38,236	$ 5,558,282	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: 01/01/20 Ending: 12/31/20

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		$ 9,860,445	$ 283,250		$ 321,486	$ 38,236	$ 5,558,282	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,860,445	$ 283,250		$ 321,486	$ 38,236	$ 5,558,282	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: 01/01/20 Ending: 12/31/20

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		$ 9,860,445	$ 283,250		$ 321,486	$ 38,236	$ 5,558,282	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 9,860,445	$ 283,250		$ 321,486	$ 38,236	$ 5,558,282	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: 01/01/20 Ending: 12/31/20

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			301,871	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	98,120	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	20,597	11
12	Grasmere Real Estate (various)	2005	98,203		20	4,910	4,910	80,666	12
13	Grasmere Real Estate (various)	2006	87,251		20	4,363	4,363	61,657	13
14	Grasmere Real Estate (various)	2007	14,669		20	733	733	10,262	14
15	Piping Repair	2008	7,309		20	365	365	4,745	15
16	Elevator Repair	2008	2,738		20	137	137	1,781	16
17	Boiler Repair	2008	9,826		20	491	491	6,383	17
18	Fire Escape Repairs	2009	9,160		20	458	458	5,496	18
19	Masonry Repairs	2009	2,810		20	141	141	1,692	19
20	USA Satellite & Cable	2009	4,810		20	281	281	4,172	20
21	Window Screen	2009	5,880		20	294	294	3,528	21
22	Boiler	2009	6,061		20	303	303	3,636	22
23	Masonry Repairs	2010	51,315		20	2,566	2,566	28,226	23
24	Replace Plumbing in rooms 204 & 208	2011	3,610		20	181	181	1,629	24
25	New Sprinkler Heads	2012	15,512		20	776	776	6,984	25
26	Replace Underground Steam Pipes	2012	13,950		20	698	698	6,282	26
27	Replace Kitchen Floor and Walls	2012	8,970		20	449	449	4,041	27
28	Remove and Replace Walls in Dishwasher Room	2012	3,420		20	171	171	1,539	28
29	Roofing Repairs	2012	3,596		20	180	180	1,620	29
30	Remove and Replace Chimney	2012	8,280		20	414	414	3,726	30
31	Replace Steel Doors, Flooring	2012	9,890		20	495	495	4,455	31
32	Replace Window Hardware	2012	9,532		20	477	477	4,293	32
33	New Window Screens	2012	2,610		20	131	131	1,179	33
34	TOTAL (lines 1 thru 33)		$ 815,879	$		$ 25,745	$ 25,745	$ 668,580	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: 01/01/20 Ending: 12/31/20

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	$		$ 25,745	$ 25,745	$ 668,580	1
2	Window Replacement Parts	2012	7,638		20	382	382	3,438	2
3	Install Mass Notification System & Wireless Nurse Call System	2013	67,027		20	3,351	3,351	26,808	3
4	South Side 2nd Floor and North Side 3rd Floor	2013	86,984		20	4,349	4,349	34,792	4
5	Exterior Steel Door Replacement	2017	3,800		20	190	190	760	5
6	Repair Brick & Tuckpoint on Back Wall of Building	2017	12,000		20	600	600	2,400	6
7	Kitchen Floor Tile Replacement	2017	15,000		20	750	750	3,000	7
8	Door/Hinge Replacement - 3rd Floor Stairwell & Northside Eastwood	2017	4,601		20	230	230	920	8
9	Paint Exterior Wall & Ceiling on Back Side of Building	2017	10,000		20	500	500	2,000	9
10	Electrical Box Main Breaker Replacement	2017	7,000		20	350	350	1,400	10
11	Door Repairs-3rd Flr Stairwell, Activity Rm, Nurses Station, Maint Rr	2017	5,000		20	250	250	1,000	11
12	3rd Floor - Remove Wallpaper, Patch Walls, Paint	2017	38,382		20	1,919	1,919	7,676	12
13	Tuckpoint Interior Courtyard Walls and Chimney	2017	155,500		20	7,775	7,775	31,100	13
14									14
15									15
16									16
17									17
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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,228,811	$		$ 46,391	$ 46,391	$ 783,874	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: 01/01/20 Ending: 12/31/20

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	35,845	919	35	919		16,812	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	11,227	249	35	249		3,357	4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	29,611		20			29,611	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	34,895		20			34,895	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,734		20			1,734	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	313	16	20	16		188	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	3,003	150	20	150		1,051	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	493	25	20	25		319	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,949	97	20	97		487	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,380	169	20	169		676	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,549	77	20	77		232	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	584	29	20	29		58	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	156	8	20	8		8	18
19									19
20	Allocated from Extended Care Consulting	2007	215	11	20	11		151	20
21	Allocated from Extended Care Consulting	2009	129	6	20	6		77	21
22	Allocated from Extended Care Consulting	2010	1,262	63	20	63		694	22
23	Allocated from Extended Care Consulting	2011	454	23	20	23		227	23
24	Allocated from Extended Care Consulting	2012	150	7	20	7		67	24
25	Allocated from Extended Care Consulting	2014	2,075	104	20	104		726	25
26	Allocated from Extended Care Consulting	2016	2,488	124	20	124		622	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 131,508	$ 2,078		$ 2,078	$	$ 91,993	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: 01/01/20 Ending: 12/31/20

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		$ 131,508	$ 2,078		$ 2,078	$	$ 91,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 131,508	$ 2,078		$ 2,078	$	$ 91,993	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: 01/01/20 Ending: 12/31/20

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	$ 41,094	$ 1,066	$ 2,128	$ 1,062	10	$ 36,011	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,901,910				10	1,901,910	73
74								74
75	TOTALS	$ 1,943,004	$ 1,066	$ 2,128	$ 1,062		$ 1,937,921	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	1,191				5	1,191	77
78										78
79										79
80	TOTALS			$ 18,726	$	$	$		$ 18,726	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,648,186	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 284,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 323,614	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,298	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,514,929	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: 01/01/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 6,069 Description: See Attached
(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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 2,285,246	$ 2,387,835	1
2	Cash-Patient Deposits	47,041	47,041	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	107,642	107,642	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,897	66,439	6
7	Other Prepaid Expenses	9,182	9,182	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	2,013	557,687	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,499,021	$ 3,175,826	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	2,320,312	3,918,198	15
16	Equipment, at Historical Cost	330,224	1,987,959	16
17	Accumulated Depreciation (book methods)	(1,299,834)	(7,183,939)	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	2,665	795,973	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,353,367	$ 5,896,191	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,852,388	$ 9,072,017	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,159,322	$ 3,161,958	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,752	49,752	28
29	Short-Term Notes Payable		265,557	29
30	Accrued Salaries Payable	205,354	205,354	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,573	2,573	31
32	Accrued Real Estate Taxes(Sch.IX-B)		265,113	32
33	Accrued Interest Payable		24,056	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	9,885	9,885	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,426,886	$ 3,984,248	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,526,833	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	54,888	54,888	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 54,888	$ 6,581,721	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,481,774	$ 10,565,969	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 370,614	$ (1,493,952)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,852,388	$ 9,072,017	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (568,889)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (568,889)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	939,503	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)**	$ 939,503	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)**	$ 370,614	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	$ 6,852,751	1
2	Discounts and Allowances for all Levels	(2,315)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,850,436	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	2,358	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,770	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,128	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,301	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,301	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,390,760	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,390,760	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,270,625	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,674,982	31
32	Health Care	2,556,422	32
33	General Administration	1,974,190	33
	B. Capital Expense		
34	Ownership	1,125,528	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)***	$ 7,331,122	40
41	**Income before Income Taxes (line 30 minus line 40)****	939,503	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 939,503	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,800,720	44
45	Private Pay - Net Inpatient Revenue	49,716	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)	$ 6,850,436	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	1,655	1,776	$ 77,689	$ 43.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,655	1,936	52,871	27.31	3
4	Licensed Practical Nurses	15,216	16,743	490,456	29.29	4
5	CNAs & Orderlies	52,582	58,911	929,008	15.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,977	2,274	66,781	29.37	9
10	Activity Assistants	5,713	6,374	87,511	13.73	10
11	Social Service Workers	24,984	28,020	634,178	22.63	11
12	Dietician					12
13	Food Service Supervisor	2,133	2,398	60,459	25.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,484	4,029	73,062	18.13	15
16	Dishwashers	11,659	13,225	206,437	15.61	16
17	Maintenance Workers	10,363	11,389	189,366	16.63	17
18	Housekeepers	21,591	24,251	381,192	15.72	18
19	Laundry					19
20	Administrator	1,987	2,192	113,522	51.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,896	2,158	47,100	21.83	23
24	Clerical	5,869	6,983	119,660	17.14	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	1,874	2,156	35,007	16.24	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,622	5,638	63,805	11.32	33
34	TOTAL (lines 1 - 33)	170,260	190,453	$ 3,628,104 *	$ 19.05	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	6,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	21,538	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				45
46	Other(specify)				46
47	Psychiatrist	Monthly	300	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 28,138		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laura Feliciano-Dixon	Administrator	0	$ 113,522
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,522

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	$ 23,800
Personnel Planners	Unemployment Consultant	306
Red Eyed Moose Technologies	Software Support	4,406
MatrixCare	Billing Software	29,008
National Datacare Corp.	Resident Fund processing	2,731
Propay HR	Payroll Processing	26,676
Extended Care Consulting	Home Office Expense	332,160
See Attached	Legal	12,292
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 431,379

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,883
Unemployment Compensation Insurance	21,401
FICA Taxes	265,998
Employee Health Insurance	212,128
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	32,502
Other Employee Benefits	2,959
Holiday Expense	3,728
TOTAL (agree to Schedule V, line 22, col.8)	$ 606,599

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,425
Advertising: Employee Recruitment	16,482
Health Care Worker Background Check	
(Indicate # of checks performed 304)	3,038
Patient Background Checks	
Dues & Subscriptions	19,815
Licenses & Fees	10,028
See Supplemental Schedule	3,040
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,828

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,330
See Supplemental Schedule	496
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,826

**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 $28,020**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **324** Line **10**

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

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

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

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

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

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

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

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

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

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