



Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	74,654	806		75,460	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,654	806		75,460	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.45%

D. How many bed-hold days during this year were paid by Public Aid? 2,444 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/99 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/00 Fiscal Year: 12/31/00  
\* All facilities other than governmental must report on the accrual basis.

Facility Name &amp; ID Number

GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	170,787	42,956	16,238	229,981		229,981	(1,490)	228,491		1
2	Food Purchase		243,267		243,267	(32,336)	210,931	(1,386)	209,545		2
3	Housekeeping	199,592	43,080		242,672		242,672	2,679	245,351		3
4	Laundry		9,278	20,666	29,944		29,944		29,944		4
5	Heat and Other Utilities			108,962	108,962		108,962	2,055	111,017		5
6	Maintenance	75,039		113,118	188,157		188,157	16,822	204,979		6
7	Other (specify):*							2,574	2,574		7
8	<b>TOTAL General Services</b>	445,418	338,581	258,984	1,042,983	(32,336)	1,010,647	21,254	1,031,901		8
<b>B. Health Care and Programs</b>											
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	914,739	21,435	5,160	941,334		941,334	30,194	971,528		10
10a	Therapy							6,267	6,267		10a
11	Activities	216,642	31,538	5,537	253,717		253,717	(818)	252,899		11
12	Social Services	396,446	4,400	16,438	417,284		417,284	1,833	419,117		12
13	Nurse Aide Training										13
14	Program Transportation			5,898	5,898		5,898		5,898		14
15	Other (specify):*							5,592	5,592		15
16	<b>TOTAL Health Care and Programs</b>	1,527,827	57,373	36,333	1,621,533		1,621,533	43,068	1,664,601		16
<b>C. General Administration</b>											
17	Administrative			291,820	291,820		291,820	23,809	315,629		17
18	Directors Fees										18
19	Professional Services			331,423	331,423		331,423	(286,020)	45,403		19
20	Dues, Fees, Subscriptions & Promotions			58,804	58,804		58,804	(21,843)	36,961		20
21	Clerical & General Office Expenses	210,317	19,402	123,576	353,295		353,295	47,764	401,059		21
22	Employee Benefits & Payroll Taxes			342,027	342,027	32,336	374,363	(17,165)	357,198		22
23	Inservice Training & Education			257	257		257		257		23
24	Travel and Seminar			1,651	1,651		1,651	5,957	7,608		24
25	Other Admin. Staff Transportation			5,458	5,458		5,458	(4,595)	863		25
26	Insurance-Prop.Liab.Malpractice			38,345	38,345		38,345	1,369	39,714		26
27	Other (specify):*							33,646	33,646		27
28	<b>TOTAL General Administration</b>	210,317	19,402	1,193,361	1,423,080	32,336	1,455,416	(217,078)	1,238,339		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,183,562	415,356	1,488,678	4,087,596		4,087,596	(152,755)	3,934,841		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.

**GRASMERE PLACE, LLC**  
**0044271**  
**COST REPORT RECLASSIFICATIONS**  
**01/01/00**  
**12/31/00**

SCHEDULE V LINE #
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22	EMPLOYEE BENEFITS	<u>32,336</u>	
2	FOOD		<u>32,336</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u>          </u>	
19	PROFESSIONAL FEES		<u>          </u>

To reclass cost of appealing real estate taxes

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			19,938	19,938		19,938	323,011	342,949			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,081	2,081		2,081	954,729	956,810			32
33	Real Estate Taxes			110,567	110,567		110,567	(13,085)	97,482			33
34	Rent-Facility & Grounds			999,297	999,297		999,297	(993,974)	5,323			34
35	Rent-Equipment & Vehicles			16,228	16,228		16,228	4,380	20,608			35
36	Other (specify):*							141,621	141,621			36
37	<b>TOTAL Ownership</b>			1,148,111	1,148,111		1,148,111	416,682	1,564,793			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			79	79		79		79			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,584	118,584		118,584		118,584			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			118,663	118,663		118,663		118,663			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,183,562	415,356	2,755,452	5,354,370		5,354,370	263,927	5,618,297			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 GRASMER PLACE, LLC

# 0044271

Report Period Beginning: 01/01/00

Ending: 12/31/00

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(180,736)	30		9
10	Interest and Other Investment Income	(9,454)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(26)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,000)	21		24
25	Fund Raising, Advertising and Promotional	(4,010)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,394)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,065)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (293,685)		\$	30

OHF 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	2	
		Amount	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)	557,612		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 557,612		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 263,927		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0044271

Report Period Beginning: 01/01/00

Ending: 12/31/00

	Amount	Sch. V Line Reference
1		6
2		21
3		21
4		20
5		21
6		10
7		21
8		21
9		19
10		10
11		11
12		12
13		13
14		14
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16		16
17		17
18		18
19		19
20		20
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73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90		90
<b>Total</b>	<b>(15,065)</b>	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number GRASMERE PLACE, LLC

# 0044271 Report Period Beginning:

01/01/00

Ending:

12/31/00

## 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)	
	<b>A. General Services</b>													
1	Dietary			6,394	(7,884)								(1,490)	1
2	Food Purchase	(26)		(1,360)									(1,386)	2
3	Housekeeping			2,679									2,679	3
4	Laundry													4
5	Heat and Other Utilities			2,055									2,055	5
6	Maintenance			16,822									16,822	6
7	Other (specify):*			2,574									2,574	7
8	<b>TOTAL General Services</b>	<b>(26)</b>		<b>29,164</b>	<b>(7,884)</b>								<b>21,254</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(34)		32,445					(2,217)				30,194	10
10a	Therapy			6,267									6,267	10a
11	Activities			2,718	(3,536)								(818)	11
12	Social Services			2,396	(563)								1,833	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,592									5,592	15
16	<b>TOTAL Health Care and Programs</b>	<b>(34)</b>		<b>49,418</b>	<b>(4,098)</b>				<b>(2,217)</b>				<b>43,068</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			43,261	(99,620)	80,168							23,809	17
18	Directors Fees													18
19	Professional Services	(3,500)		11,390	(293,910)								(286,020)	19
20	Fees, Subscriptions & Promotions	(4,320)	515	1,672	(19,710)								(21,843)	20
21	Clerical & General Office Expenses	(95,615)	20	154,074	(10,715)								47,764	21
22	Employee Benefits & Payroll Taxes				(17,165)								(17,165)	22
23	Inservice Training & Education													23
24	Travel and Seminar			5,957									5,957	24
25	Other Admin. Staff Transportation			265	(4,860)								(4,595)	25
26	Insurance-Prop.Liab.Malpractice			1,369									1,369	26
27	Other (specify):*			22,762		10,884							33,646	27
28	<b>TOTAL General Administration</b>	<b>(103,435)</b>	<b>535</b>	<b>240,750</b>	<b>(445,980)</b>	<b>91,052</b>							<b>(217,078)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(103,495)</b>	<b>535</b>	<b>319,332</b>	<b>(457,962)</b>	<b>91,052</b>			<b>(2,217)</b>				<b>(152,755)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number GRASMERE PLACE, LLC# 0044271

Report Period Beginning:

01/01/00 Ending:12/31/00

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

	Capital Expense	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)	
<b>30</b>	<b>D. Ownership</b>													
	Depreciation	(180,736)	489,372	14,375									323,011	30
<b>31</b>	Amortization of Pre-Op. & Org.													31
<b>32</b>	Interest	(9,454)	948,619	15,564									954,729	32
<b>33</b>	Real Estate Taxes		(15,868)	2,783									(13,085)	33
<b>34</b>	Rent-Facility & Grounds		(999,297)	5,323									(993,974)	34
<b>35</b>	Rent-Equipment & Vehicles			4,380									4,380	35
<b>36</b>	Other (specify):*		141,621										141,621	36
<b>37</b>	<b>TOTAL Ownership</b>	(190,190)	564,447	42,425									416,682	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
<b>38</b>	Medically Necessary Transportation													38
<b>39</b>	Ancillary Service Centers													39
<b>40</b>	Barber and Beauty Shops													40
<b>41</b>	Coffee and Gift Shops													41
<b>42</b>	Provider Participation Fee													42
<b>43</b>	Other (specify):*													43
<b>44</b>	<b>TOTAL Special Cost Centers</b>													44
<b>45</b>	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(293,685)	564,982	361,757	(457,962)	91,052			(2,217)				263,927	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				GRASMERE REAL ESTATE, LLC.		BUILDING CO.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENTAL INCOME	\$ 999,297	GRASMERE REAL ESTATE, LLC.		\$	(999,297)	1
2	V	32 INTEREST INCOME		GRASMERE REAL ESTATE, LLC.		(8,530)	(8,530)	2
3	V	32 INTEREST EXPENSE - LOAN		GRASMERE REAL ESTATE, LLC.		106,143	106,143	3
4	V	32 INTEREST EXPENSE - MORT		GRASMERE REAL ESTATE, LLC.		851,006	851,006	4
5	V	33 RE TAX PRIOR YEAR		GRASMERE REAL ESTATE, LLC.		(15,868)	(15,868)	5
6	V	21 BANK CHARGES		GRASMERE REAL ESTATE, LLC.		20	20	6
7	V	20 TRUST FEES		GRASMERE REAL ESTATE, LLC.		515	515	7
8	V	36 AMORTIZATION		GRASMERE REAL ESTATE, LLC.		91,674	91,674	8
9	V	30 DEPRECIATION		GRASMERE REAL ESTATE, LLC.		489,372	489,372	9
10	V	36 M/P INSURANCE EXPENSE		GRASMERE REAL ESTATE, LLC.		49,947	49,947	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 999,297			\$ 1,564,279	\$ * 564,982	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V	1	DIETARY	\$		100.00%	\$ 6,394	\$	6,394	15
16	V	2	FOOD				(1,360)		(1,360)	16
17	V	3	HOUSEKEEPING				2,679		2,679	17
18	V	5	UTILITIES				2,055		2,055	18
19	V	6	REPAIRS AND MAINT.				16,822		16,822	19
20	V	7	EMP. BEN. - GEN. SERV.				2,574		2,574	20
21	V	10	NURSING				32,445		32,445	21
22	V	10A	THERAPY				6,267		6,267	22
23	V	11	ACTIVITIES				2,718		2,718	23
24	V	12	SOCIAL SERVICES				2,396		2,396	24
25	V	15	EMP. BEN. - HEALTHCARE				5,592		5,592	25
26	V	17	ADMINISTRATIVE				43,261		43,261	26
27	V	19	PROFESSIONAL FEES				11,390		11,390	27
28	V	20	DUES, SUBSCRIPTIONS				1,672		1,672	28
29	V	21	CLERICAL AND GENERAL				154,074		154,074	29
30	V	24	SEMINARS				5,957		5,957	30
31	V	25	AUTO EXPENSE				265		265	31
32	V	26	INSURANCE				1,369		1,369	32
33	V	27	EMP. BEN. - GEN. ADMIN.				22,762		22,762	33
34	V	30	DEPRECIATION				14,375		14,375	34
35	V	32	INTEREST	0			15,564		15,564	35
36	V	33	REAL ESTATE TAXES				2,783		2,783	36
37	V	34	BUILDING RENT - UNRELATED				5,323		5,323	37
38	V	35	EQUIPMENT RENTAL				4,380		4,380	38
39	Total			\$			\$ 361,757	\$ *	361,757	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIETARY CONS	\$ 7,884	0	100.00%	\$ 0	\$	(7,884)	15
16	V	19 ACCOUNTING	15,000			0		(15,000)	16
17	V	19 ANCIL ADMIN FEE	25,920			0		(25,920)	17
18	V	19 BOOKEEPING	44,064			0		(44,064)	18
19	V	19 DATA PROCESSING	7,776			0		(7,776)	19
20	V	19 LEGAL	19,710			0		(19,710)	20
21	V	19 MANAGEMENT FEE	181,440			0		(181,440)	21
22	V	19 PROFESSIONAL FEES	0			0			22
23	V	20 ADVERTISING	19,710			0		(19,710)	23
24	V	25 REBILL BUS	4,860			0		(4,860)	24
25	V	0				0			25
26	V	22 HOME OFFICE PAYROLL TAX	17,165			0		(17,165)	26
27	V	1 REBILL. PAYROLL DIETARY	0			0			27
28	V	3 REBILL. PAYROLL HSKPNG	0			0			28
29	V	6 REBILL. PAYROLL MAINT.	0			0			29
30	V	10 REBILL. PAYROLL NURSING	0			0			30
31	V	10A REBILL. PAYROLL THPY CONS.	0			0			31
32	V	11 REBILL. PAYROLL ACTIVITIES	3,536			0		(3,536)	32
33	V	12 REBILL. PAYROLL SOC. SERV.	563			0		(563)	33
34	V	17 REBILL. PAYROLL ADMIN.	99,620			0		(99,620)	34
35	V	21 REBILL. PAYROLL CLERICAL	10,715			0		(10,715)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 457,962			\$ 0	\$ *	(457,962)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10 NURSING	\$	CARE CENTERS, INC.	100.00%	\$ 0	\$	15	
16	V	15 EMP. BEN HEALTHCARE				0		16	
17	V	17 ADMINISTRATIVE				80,168	80,168	17	
18	V	27 EMP. BEN GEN. ADMIN.				10,884	10,884	18	
19	V	0				0		19	
20	V	0				0		20	
21	V	0				0		21	
22	V	0				0		22	
23	V	0				0		23	
24	V	0				0		24	
25	V	0				0		25	
26	V	0				0		26	
27	V	0				0		27	
28	V	0				0		28	
29	V	0				0		29	
30	V	0				0		30	
31	V	0				0		31	
32	V	0				0		32	
33	V	0				0		33	
34	V	0						34	
35	V	0	0					35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 91,052	\$ *	91,052	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETARY	\$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	\$ 0	\$	15
16	V	2 FOOD				0		16
17	V	6 MAINTENANCE				0		17
18	V	7 EMP. BEN. - GEN. SERV.				0		18
19	V	10 NURSING				0		19
20	V	17 ADMINISTRATIVE				0		20
21	V	19 PROFESSIONAL FEES				0		21
22	V	20 DUES, FEES, SUB.				0		22
23	V	21 CLERICAL & GENERAL				0		23
24	V	24 SEMINARS				0		24
25	V	25 TRAVEL				0		25
26	V	32 INTEREST				0		26
27	V	35 RENT - EQUIPMENT & VEHICLES				0		27
28	V	39 ANCILLARY ENTERAL SUPPLIES				0		28
29	V	1 DIETARY SUPP				0		29
30	V	39 ANCILLARY SUPP				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0						34
35	V	0	0					35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 CLERICAL AND GENERAL	\$	CARE CENTERS, INC.	100.00%	\$ 0	\$	15
16	V	27 EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0				0		17
18	V	0				0		18
19	V	0				0		19
20	V	0				0		20
21	V	0				0		21
22	V	0				0		22
23	V	0				0		23
24	V	0				0		24
25	V	0				0		25
26	V	0				0		26
27	V	0				0		27
28	V	0				0		28
29	V	0				0		29
30	V	0				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0						34
35	V	0	0					35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)			
		Item	Amount	Name of Related Organization							
15	V	10	MEDICALSUPPLIES	\$		XCEL MEDICAL SUPPLY LLC	100.00%	\$ 11,689	\$ 11,689	15	
16	V									16	
17	V									17	
18	V									18	
19	V	10	MEDICALSUPPLIES		13,906					(13,906)	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			\$	13,906			\$ 11,689	\$ *	(2,217)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 106,647	\$ 106,647	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INS.	106,647				(106,647)	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		\$ 106,647			\$ 106,647	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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	<b>Total</b>		\$				\$	0 \$ *	39

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

Facility Name & ID Number GRASMERE PLACE, LLC # 0044271 Report Period Beginning: 01/01/00 Ending: 12/31/00

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0%	SEE ATTACHED	2.45	3.40%	Mgt. Fee	\$ 180,000	17-3	1
2	Mark Steinberg	Relative	Administrative	0%	SEE ATTACHED	2.5	5%	Alloc Salary	2,214	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 182,214		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, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending: 12/31/00

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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, LLC

# 0044271 Report Period Beginning: 01/01/00

Ending: 12/31/00

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 CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number (708)449-9090  
 Fax Number (708)449-7070

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	1,512,231	32	\$ 128,135	\$ 128,055	75,460	\$ 6,394	1
2	2	FOOD	1,512,231	32	(27,254)		75,460	(1,360)	2
3	3	HOUSEKEEPING	1,512,231	32	53,695	52,345	75,460	2,679	3
4	5	UTILITIES	1,512,231	32	41,192		75,460	2,055	4
5	6	REPAIRS AND MAINT.	1,512,231	32	337,107	220,731	75,460	16,822	5
6	7	EMP. BEN. - GEN. SERV.	1,512,231	32	51,593		75,460	2,574	6
7	10	NURSING	1,512,231	32	650,209	657,173	75,460	32,445	7
8	10A	THERAPY	1,512,231	32	125,600	125,524	75,460	6,267	8
9	11	ACTIVITIES	1,512,231	32	54,474	54,163	75,460	2,718	9
10	12	SOCIAL SERVICES	1,512,231	32	48,011	48,011	75,460	2,396	10
11	15	EMP. BEN. - HEALTHCARE	1,512,231	32	112,058		75,460	5,592	11
12	17	ADMINISTRATIVE	1,512,231	32	866,963	862,068	75,460	43,261	12
13	19	PROFESSIONAL FEES	1,512,231	32	228,254		75,460	11,390	13
14	20	DUES, SUBSCRIPTIONS	1,512,231	32	33,513		75,460	1,672	14
15	21	CLERICAL AND GENERAL	1,512,231	32	3,087,659	2,709,599	75,460	154,074	15
16	24	SEMINARS	1,512,231	32	119,372		75,460	5,957	16
17	25	AUTO EXPENSE	1,512,231	32	5,310		75,460	265	17
18	26	INSURANCE	1,512,231	32	27,429		75,460	1,369	18
19	27	EMP. BEN. - GEN. ADMIN.	1,512,231	32	456,163		75,460	22,762	19
20	30	DEPRECIATION	1,512,231	32	288,068		75,460	14,375	20
21	32	INTEREST	1,512,231	32	311,903		75,460	15,564	21
22	33	REAL ESTATE TAXES	1,512,231	32	55,780		75,460	2,783	22
23	34	BUILDING RENT - UNRELATE	1,512,231	32	106,673		75,460	5,323	23
24	35	EQUIPMENT RENTAL	1,512,231	32	87,772		75,460	4,380	24
25	TOTALS				\$ 7,249,679	\$ 4,857,669		\$ 361,757	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271 Report Period Beginning: 01/01/00

Ending: 12/31/00

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271 Report Period Beginning: 01/01/00

Ending: 12/31/00

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 CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

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	DIRECT ALLOCATION	9	307,262	298,696			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION	9	39,980				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION	24	1,436,904	1,436,850		80,168	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION	24	191,316			10,884	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				\$ 1,975,462	\$ 1,735,546		\$ 91,052	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

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	DIETARY	HEALTH SYSTEMS INC. 2,287,765	28	496,134	378,284			1
2	2	FOOD	HEALTH SYSTEMS INC. 2,287,765	28	960,501				2
3	6	MAINTENANCE	HEALTH SYSTEMS INC. 2,287,765	28	4,392				3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC. 2,287,765	28	47,282				4
5	10	NURSING	HEALTH SYSTEMS INC. 2,287,765	28	700				5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC. 2,287,765	28	25,000				6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC. 2,287,765	28	7,428				7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC. 2,287,765	28	1,836				8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC. 2,287,765	28	24,796				9
10	24	SEMINARS	HEALTH SYSTEMS INC. 2,287,765	28	1,526				10
11	25	TRAVEL	HEALTH SYSTEMS INC. 2,287,765	28	43,326				11
12	32	INTEREST	HEALTH SYSTEMS INC. 2,287,765	28	1,489				12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC. 2,287,765	28	2,182				13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC. 2,287,765	28	32,397				14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,648,989	\$ 378,284		\$	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

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	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075		1	
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401			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					\$ 35,476	\$ 31,075		\$	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 XCEL MEDICAL SUPPLY LLC  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-2330  
 Fax Number ( 708)449-3236

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	MEDICALSUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 11,689	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				\$	\$		\$ 11,689	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION		\$	\$		\$ 106,647	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				\$	\$		\$ 106,647	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271 Report Period Beginning: 01/01/00

Ending: 12/31/00

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271 Report Period Beginning: 01/01/00

Ending: 12/31/00

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	<b>TOTALS</b>				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	BUILDING PARTNERSHIP	X		MORTGAGE	\$71,078.00	01/26/99	\$ 9,120,000	\$ 9,518,795	02/01/01	8.00%	\$ 851,005	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	SHAREHOLDERS LOAN										76,000	6								
7	RELATED PARTY LOANS										30,143	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$71,078.00		\$ 9,120,000	\$ 9,518,795			\$ 957,148	9								
<b>B. Non-Facility Related*</b>																				
10	Supplemental Schedule										(338)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (338)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 9,120,000	\$ 9,518,795			\$ 956,810	15								

\* 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, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	A-1 CORPORATION		X	INSURANCE FINANCING			\$	\$			\$ 2,081	1
2	ALLOCATION - CCI	X									15,564	2
3	Interest Income-Diawa Loan										(5,258)	3
4	Interest Inocme-Market										(4,195)	4
5	Interest Income - Building Co.	X									(8,530)	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							\$	\$			\$ (338)	21

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>118,534</b>	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.)	\$	<b>108,217</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(10,317)</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>107,799</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>97,482</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	N/A	8
	1996	N/A	9
	1997	N/A	10
	1998	106,146	11
	1999	105,434	12

<b>FOR OFF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION\$		16

**2000 REAL ESTATED TAX ACCRUAL=1999 ACCRUAL 102666 \* 1.05=107799**

**OPENING ACCRUAL ADJUSTED BY \$15,868 FOR PRIOR YEAR R/E TAX**

**ALLOC FROM CARE CENTERS \$2,783 (INCLUDED IN LINE 2)**

**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.**

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  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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, nurse aide 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  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1999	\$ 800,000	1
2	ALLOC - CCI			3,194	2
3	TOTALS			\$ 803,194	3

Facility Name &amp; ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	216		1999	1999	\$ 5,578,000	\$ 143,026	35	\$ 159,371	\$ 16,345	\$ 305,461	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING		1999		7,000	179	20	350	171	379	9
10	EQUIPMENT REPAIR		1999		719	291	20	36	36	66	10
11	A/C UNITS		1999		890	235	20	45	45	71	11
12	SPRINKLERS		1999		899	23	20	45	22	49	12
13	PLUMBING		1999		939	24	20	47	23	51	13
14	DRYWALL		1999		8,700	223	20	435	212	471	14
15	BOILER		1999		2,842	73	20	142	69	213	15
16	RADIATOR RENOV		1999		653	17	20	33	16	36	16
17	PLUMBING RENOVATION		1999		777	20	20	39	19	46	17
18	FLOORING		1999		436	11	20	22	11	33	18
19	FLOORING		1999		4,704	121	20	235	114	333	19
20	COMPRESSOR		1999		1,695	245	20	85	85	135	20
21	COVE BASE		1999		371	268	20	19	9	29	21
22	HVAC RENOVATION		1999		1,015	320	20	51	25	94	22
23	FLOORING		1999		512	376	20	26	13	39	23
24	PAGE 12-2 REP TOTALS				371,871	9,534		18,595	9,061	18,595	24
25	PAGE 12-1 REP TOTALS				71,148	1,893		2,360	467	9,476	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				87,843	2,719		4,143	1,424	4,143	33
34	PAGE 12B TOTALS				101,000	1,624		2,474	850	2,474	34
35	PAGE 12A TOTALS				123,291	3,435		4,609	2,363	5,158	35
36	TOTAL (lines 4 thru 35)				\$ 6,365,305	\$ 164,657		\$ 193,162	\$ 31,380	\$ 347,352	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.

Facility Name &amp; ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING		1999		507	13	20	25	12	27	9
10	BOILER		1999		875	22	20	44	22	55	10
11	FLOORING		1999		12,587	323	20	629	306	734	11
12	KITCHEN WIRING		1999		7,805	376	20	390	190	455	12
13	HVAC RENOVATION		1999		948	24	20	47	23	86	13
14	BOILER		1999		5,719	147	20	286	139	453	14
15	BOILER		1999		544		20	27	27	36	15
16	A/C RENOV		1999		750	554	20	38	38	41	16
17	WATER HEATER		1999		819		20	41	41	48	17
18	CALL BUTTONS		1999		981		20	49	49	61	18
19	COOLER RENOVATION		1999		1,152		20	58	58	82	19
20	ALARM COVERS		1999		1,150		20	58	58	92	20
21	WATER HEATER		1999		1,406	459	20	70	70	111	21
22	HVAC RENOVATION		1999		719	18	20	36	18	66	22
23	ELECTRICAL WIRING		2000		1,923	14	20	32	18	32	23
24	RADIATOR RENOV		2000		1,616	29	20	61	32	61	24
25	FRONT DOOR REPAIR		2000		650	9	20	19	10	19	25
26	FRONT DOOR REPAIR		2000		675	8	20	17	9	17	26
27	CARPETING INSTALL		2000		11,844	165	20	345	180	345	27
28	ELECTRIC WIRING		2000		21,450	298	20	626	328	626	28
29	TOILETS		2000		574	115	20	48	(67)	48	29
30	LANDSCAPING		2000		2,001	28	20	58	30	58	30
31	BINDER ELECTRIC		2000		6,332	61	20	132	71	132	31
32	DEPOSIT		2000		17,000	273	20	567	294	567	32
33	TOILETS		2000		653	131	20	43	(88)	43	33
34	PLASTER/PAINT		2000		20,000	321	20	667	346	667	34
35	PAINT		2000		2,611	47	20	196	149	196	35
36	TOTAL (lines 4 thru 35)				\$ 123,291	\$ 3,435		\$ 4,609	\$ 2,363	\$ 5,158	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.

Facility Name &amp; ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		FOOD PROCESSOR	2000		930	15	20	31	16	31	9
10		TOILETS	2000		653	131	20	43	(88)	43	10
11		LAVATORY REMODELING	2000		603	1	20	3	2	3	11
12		PLUMBING REPAIR	2000		653	4	20	8	4	8	12
13		FURNITURE FOR PARK	2000		12,695	122	20	265	143	265	13
14		INSTALLN OF BSKTBL S	2000		2,304	22	20	48	26	48	14
15		PLUMBING REPAIR	2000		1,960	392	20	82	(310)	82	15
16		NURSING STATION CBNT	2000		7,065	23	20	59	36	59	16
17		COOLER RENOV	2000		3,052	10	20	26	16	26	17
18		FIRE ALARM	2000		3,169	10	20	26	16	26	18
19		FIRE PUMP REPAIR	2000		1,867	18	20	39	21	39	19
20		BOILER REPAIR	2000		2,629	3	20	11	8	11	20
21		ROOF REPAIR	2000		7,220	39	20	90	51	90	21
22		INSTALL VCT TILE	2000		1,569	38	20	78	40	78	22
23		REPLACEMENT PIPING	2000		4,996	5	20	21	16	21	23
24		INSTALLATION OF RDTR	2000		1,507	2	20	6	4	6	24
25		RADIATOR REPAIR	2000		564	1	20	2	1	2	25
26		DRAPES	2000		4,840	5	20	20	15	20	26
27		CALL STATION REPAIR	2000		939	1	20	4	3	4	27
28		PLUMBING SUPPLIES	2000		980	1	20	4	3	4	28
29		PLUMBING SUPPLIES	2000		980	3	20	8	5	8	29
30		HOT WATER HEATER REP	2000		500	7	20	15	8	15	30
31		FIRE ALARM REPAIR	2000		2,495	3	20	10	7	10	31
32		PAINT	2000		15,000	337	20	688	351	688	32
33		PLASTER	2000		15,000	273	20	563	290	563	33
34		REFRIGE RENOV	2000		2,200	44	20	92	48	92	34
35		PLUMBING RENOV	2000		4,630	114	20	232	118	232	35
36		TOTAL (lines 4 thru 35)			\$ 101,000	\$ 1,624		\$ 2,474	\$ 850	\$ 2,474	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	PAIN		2000		1,450	32	20	67	35	67	9
10	DEADLOCKS		2000		626	13	20	26	13	26	10
11	WATER HEATER RENOV		2000		1,603	321	20	147	(174)	147	11
12	PLUMBING		2000		1,691	338	20	155	(183)	155	12
13	KITCHEN REMOLDELING		2000		33,147	744	20	1,519	775	1,519	13
14	COOLER RENOV		2000		518	104	20	39	(65)	39	14
15	INSTALL GREASE TRAP		2000		1,142	25	20	52	27	52	15
16	ELEVATOR REPAIR		2000		4,476	24	20	56	32	56	16
17	PLUMBING		2000		653	131	20	65	(66)	65	17
18	ELECTRIC RENOV		2000		10,037	246	20	502	256	502	18
19	PAIN		2000		1,046	26	20	52	26	52	19
20	INSTALL CARPETING		2000		588	14	20	29	15	29	20
21	INSTALL CONCRETE		2000		1,500	36	20	75	39	75	21
22	INSTALL TILES		2000		18,700	459	20	935	476	935	22
23	STEEL DOORS		2000		3,300	67	20	138	71	138	23
24	PLASTER/PAINT		2000		2,500	40	20	83	43	83	24
25	PAIN		2000		4,866	99	20	203	104	203	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 87,843	\$ 2,719		\$ 4,143	\$ 1,424	\$ 4,143	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1996	CCI - ALLOC	\$ 56,518	\$ 1,449	35	\$ 1,615	\$ 166	\$ 6,594	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		CARE CENTERS ALLOCATION		2000	68	1	20	3	2	3	9
10		CARE CENTERS ALLOCATION		1999	1,012	26	20	51	25	96	10
11		CARE CENTERS ALLOCATION		1998	418	11	20	21	10	56	11
12		CARE CENTERS ALLOCATION		1997	5,928	136	20	327	191	1,584	12
13		CARE CENTERS ALLOCATION		1997	688	159	20	30	(129)	67	13
14		CARE CENTERS ALLOCATION		1996	6,516	86	20	313	227	1,076	14
15		CARE CENTERS ALLOCATION		1994		19	20		(19)		15
16		CARE CENTERS ALLOCATION		1993		6	20		(6)		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	TOTAL (lines 4 thru 35)				\$ 71,148	\$ 1,893		\$ 2,360	\$ 467	\$ 9,476	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.

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	GRASMERE REAL ESTATE LLC		1999		192,580	4,938	20	9,629	4,691	9,629	9
10	GRASMERE REAL ESTATE LLC		1999		19,311	495	20	966	471	966	10
11	GRASMERE REAL ESTATE LLC		1999		1,573	40	20	79	39	79	11
12	GRASMERE REAL ESTATE LLC		1999		50,131	1,285	20	2,507	1,222	2,507	12
13	GRASMERE REAL ESTATE LLC		1999		17,558	450	20	878	428	878	13
14	GRASMERE REAL ESTATE LLC		1999		90,718	2,326	20	4,536	2,210	4,536	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	TOTAL (lines 4 thru 35)				\$ 371,871	\$ 9,534		\$ 18,595	\$ 9,061	\$ 18,595	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.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 1,464,430	\$ 351,033	\$ 144,014	\$ (207,019)		\$ 270,076	37
38	Current Year Purchases	31,373	5,054	1,632	(3,422)		1,632	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 1,495,803	\$ 356,087	\$ 145,646	\$ (210,441)		\$ 271,708	41

D. Vehicle Depreciation (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	
42	CCI ALLOCATION			\$ 26,846	\$ 5,816	\$ 4,141	\$ (1,675)		\$ 9,294	42
43										43
44										44
45										45
46	TOTALS			\$ 26,846	\$ 5,816	\$ 4,141	\$ (1,675)		\$ 9,294	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 8,691,148	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 526,560	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 342,949	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (180,736)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 628,354	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

GRASMERE PLACE, LLC  
0044271  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
GRASMERE PLACE, LLC	16,990	4,895	1,699	(3,196)	2,323
CARE CENTERS	47,931	6,201	5,182	(1,019)	22,220
GRASMERE REAL ESTATE, LLC	1,399,509	339,937	137,133	(202,804)	245,533
<b>TOTALS</b>	<b>1,464,430</b>	<b>351,033</b>	<b>144,014</b>	<b>(207,019)</b>	<b>270,076</b>

<b>LINE 29: CURRENT YEAR</b>					
GRASMERE PLACE, LLC	28,673	4,590	1,569	(3,021)	1,569
CARE CENTERS	2,700	464	63	(401)	63
GRASMERE REAL ESTATE, LLC					
<b>TOTALS</b>	<b>31,373</b>	<b>5,054</b>	<b>1,632</b>	<b>(3,422)</b>	<b>1,632</b>

<b>LINE 30: FULLY DEPRECIATED</b>					
GRASMERE PLACE, LLC					
CARE CENTERS					
GRASMERE REAL ESTATE, LLC					
<b>TOTALS</b>					

**TOTALS (Should Tie to Totals on Page 13)**

GRASMERE PLACE, LLC	45,663	9,485	3,268	(6,217)	3,892
CARE CENTERS	50,631	6,665	5,245	(1,420)	22,283
GRASMERE REAL ESTATE, LLC	1,399,509	339,937	137,133	(202,804)	245,533
<b>TOTALS</b>	<b>1,495,803</b>	<b>356,087</b>	<b>145,646</b>	<b>(210,441)</b>	<b>271,708</b>

Facility Name & ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning:

01/01/00

Ending: 12/31/00

**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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	CCI - Alloc				5,323			5
6								6
7	<b>TOTAL</b>				\$ 5,323			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: \_\_\_\_\_ \*

**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: \$ 15,744

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	Administrator		\$ 405.40	\$ 4,865	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 405.40	\$ 4,865	21

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. \_\_\_\_\_ /2001 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2002 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2003 \$ \_\_\_\_\_

\* 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.

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 Nurse Aide 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 aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>SCHEDULE**</b>									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

**SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES**

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u>                    </u>
	<u>                    </u>

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u>                    </u>
	<u>                    </u>

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 27,378	\$ 41,418	1
2 Cash-Patient Deposits	11,064	11,064	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	898,877	898,877	3
4 Supply Inventory (priced at )	3,600	3,600	4
5 Short-Term Investments			5
6 Prepaid Insurance	15,995	102,546	6
7 Other Prepaid Expenses	13,153	13,153	7
8 Accounts Receivable (owners or related parties)	71,390	221,390	8
9 Other(specify): <a href="#">See supplemental schedule</a>	339,167	928,613	9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,380,624	\$ 2,220,661	10
<b>B. Long-Term Assets</b>			
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 Cos	329,937	701,807	15
16 Equipment, at Historical Cost	59,468	1,430,801	16
17 Accumulated Depreciation (book methods)	(24,690)	(826,965)	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):	3,163	3,163	22
23 Other(specify): <a href="#">See supplemental schedule</a>	30,208	1,007,797	23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 398,086	\$ 8,694,603	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,778,710	\$ 10,915,264	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 133,373	\$ 293,374	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	3,458	3,458	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	179,495	179,495	30
31 Accrued Taxes Payable (excluding real estate taxes)	3,556	3,556	31
32 Accrued Real Estate Taxes(Sch.IX-B)	107,799	107,799	32
33 Accrued Interest Payable		67,821	33
34 Deferred Compensation	1,473	1,473	34
35 Federal and State Income Taxes	29,606	29,606	35
<b>Other Current Liabilities(specify):</b>			
36 <a href="#">See supplemental schedule</a>			36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 458,760	\$ 686,582	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable		9,518,795	40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 <a href="#">See supplemental schedule</a>			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 9,518,795	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 458,760	\$ 10,205,377	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,319,950	\$ #REF!	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,778,710	\$ #REF!	48

\*(See instructions.)

Facility Name &amp; ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning: 01/01/00

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>	OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	32,662				
INSURANCE ESCROW	14,010	14,010			
REPLACEMENT RESERVE		222,340			
REPAIR GUARANTEE ESCROW		363,678			
N/P LOC	292,495	292,495			
Real Estate Tax Escrow - Building		36,091			
	<u>339,167</u>	<u>928,614</u>			
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
CAPITAL EXP	30,208	30,208			
HUD CLOSING		111,294			
CLOSING COSTS		63,993			
GOODWILL		802,302			
	<u>30,208</u>	<u>1,007,797</u>			

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 850,098	1
2	Restatements (describe):		2
3	<a href="#">Schedule attached</a>		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 850,098	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,225,852	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	(756,000)	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)	\$ 469,852	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,319,950	24 *

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

Facility Name & ID Number GRASMERE PLACE, LLC # 0044271 Report Period Beginning: 01/01/00 Ending: 12/31/00

---

Balance per General Ledger 850,098

Adjustments:

-

-

-

Total adjustments

-

Balance - Beginning of Year

850,098

Equity(Deficit) from Page 17 Col 1

1,319,950

Related Party

Equity(Deficit)

-45082

Income

-564981

(610,063)

Combined Equity - End of Year

709,887

**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.**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,570,714	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,570,714	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	9,454	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,454	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See supplemental schedule</a>	54	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 54	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,580,222	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,042,983	31
32	Health Care	1,621,533	32
33	General Administration	1,423,080	33
<b>B. Capital Expense</b>			
34	Ownership	1,148,111	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	79	35
36	Provider Participation Fee	118,584	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,354,370	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,225,852	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,225,852	43

\* 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.

DESCRIPTION	AMOUNT
1 MISCELLANEOUS INCOME	20
2 JURY DUTY	34
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u>54</u>

Facility Name & ID Number GRASMERE PLACE, LLC

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,295	1,523	\$ 38,889	\$ 25.53	1
2	Assistant Director of Nursing	2,174	2,241	51,130	22.82	2
3	Registered Nurses	3,058	3,436	69,924	20.35	3
4	Licensed Practical Nurses	16,878	19,857	307,895	15.51	4
5	Nurse Aides & Orderlies	50,456	57,324	426,131	7.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	9,304	10,574	131,544	12.44	9
10	Activity Assistants	7,716	9,064	85,098	9.39	10
11	Social Service Workers	24,400	26,888	396,446	14.74	11
12	Dietician	3,034	3,448	49,361	14.32	12
13	Food Service Supervisor					13
14	Head Cook	5,262	5,979	52,615	8.80	14
15	Cook Helpers/Assistants	9,023	9,915	68,811	6.94	15
16	Dishwashers					16
17	Maintenance Workers	4,834	5,651	75,039	13.28	17
18	Housekeepers	31,244	33,596	199,592	5.94	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,616	16,748	210,317	12.56	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	1,513	1,719	20,770	12.08	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	184,807	207,963	\$ 2,183,562 *	\$ 10.50	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	220	\$ 16,238	1-3	35
36	Medical Director	MONTHLY	3,300	9-3	36
37	Medical Records Consultant	MONTHLY	3,360	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,001	11-3	44
45	Social Service Consultant	MONTHLY	563	12-3	45
46	Other(specify) ART THERAPIST	MONTHLY	15,875	12-3	46
47	Activity Director - CCI		3,536	11-3	47
48					48
49	TOTAL (lines 35 - 48)	263	\$ 46,673		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$ 0		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>ADMINISTRATIVE SALARIES DIRECTLY ALLOCATED FROM HOME OFFICE (see p. 6C)</u>				<u>Workers' Compensation Insurance</u>	<u>\$ 30,942</u>	<u>IDPH License Fee</u>	<u>\$ 200</u>	
				<u>Unemployment Compensation Insurance</u>	<u>28,340</u>	<u>Advertising: Employee Recruitment</u>	<u>21,913</u>	
				<u>FICA Taxes</u>	<u>160,553</u>	<u>Health Care Worker Background Check (Indicate # of checks performed 355)</u>	<u>4,260</u>	
				<u>Employee Health Insurance</u>	<u>80,471</u>	<u>CCI - ALLOC</u>	<u>1,672</u>	
				<u>Employee Meals</u>	<u>32,336</u>	<u>LICENSES, FEES, DUES AND SUBS</u>	<u>8,915</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>ADVERTISING &amp; PROMOTION</u>	<u>4,011</u>	
				<u>CHGO EMP TAX</u>	<u>3,381</u>			
				<u>PENSION EXP</u>	<u>13,243</u>			
				<u>EMPL PHYS</u>	<u>3,013</u>			
				<u>MISC EMPLOYEE WELFARE</u>	<u>4,919</u>			
<b>TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</b>			<b>\$</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 357,198</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 36,960</b>	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>CHRIS WAYER-MGT FEES</u>			<u>\$ 200</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>MANAGEMENT FEES - SEE ATTACHED</u>			<u>192,000</u>					
<u>CCI ADMINISTRATIVE PAYROLL (ADJUSTED ON P.6B)</u>			<u>99,620</u>				<u>In-State Travel</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</b>			<b>\$ 291,820</b>					
<b>C. Professional Services</b>				<b>TOTAL</b>			<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	
Vendor/Payee	Type		Amount					
<u>SEE ATTACHED</u>	<u>COMPUTER/DATA PROC.</u>		<u>\$ 25,771</u>				<u>Seminar Expense</u>	<u>871</u>
<u>PERSONNEL PLANNERS INC</u>	<u>UNEMPLOYMENT CONS.</u>		<u>2,442</u>				<u>EDUCATION EXPENSE</u>	<u>780</u>
<u>CARE CENTERS</u>	<u>ACCOUNTING</u>		<u>15,000</u>				<u>CCI ALLOC</u>	<u>5,957</u>
<u>FROST, RUTTENBERG &amp; ROTHB</u>	<u>ACCOUNTING</u>		<u>12,980</u>					
<u>SCHWARTZ&amp;FREEMAN</u>	<u>LEGAL SERVICES</u>		<u>596</u>				<u>Entertainment Expense</u>	<u>( )</u>
<u>CARE CENTERS</u>	<u>LEGAL SERVICES</u>		<u>19,710</u>					
<u>JSO VALUATION GROUP</u>	<u>OTHER PROF SERVICES</u>		<u>3,500</u>					
<u>CARE CENTERS</u>	<u>HOME OFFICE EXPENSE</u>		<u>181,440</u>					
<u>CARE CENTERS</u>	<u>ANCILLARY ADMIN SERV.</u>		<u>25,920</u>					
<u>CARE CENTERS</u>	<u>BOOKKEEPING SERVICES</u>		<u>44,064</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)</b>			<b>\$ 331,423</b>					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number GRASMERE PLACE, LLC

# 0044271

Report Period Beginning: 01/01/00

Ending: 12/31/00

## 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. ILLINOIS COUNCIL \$4,958
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line \_\_\_\_\_
- (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 \_\_\_\_\_ NO X
- (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 of Public Aid during this cost report period. \$ 118,584  
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 of Public Aid, 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 benefit on Schedule V. \$ 32,336 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14  
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? YES  
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. \$ NONE
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. To ensure an 8 1/2 by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

**Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

**Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/ov