

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044271

Facility Name: Grasmere Place

Address: 4621 North Sheridan Rd Chicago 60640
 Number City Zip Code

County: Cook

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

HFS ID Number: 364269374001

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	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	<u>216</u>	Intermediate (ICF)	<u>216</u>	<u>78,840</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>216</u>	TOTALS	<u>216</u>	<u>78,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>73,495</u>	<u>504</u>		<u>73,999</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>73,495</u>	<u>504</u>		<u>73,999</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.86%

D. How many bed-hold days during this year were paid by the Department?

3,211 (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 2/1/99

J. Was the facility purchased or leased after January 1, 1978?

YES Date 2/1/99 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: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	A. General Services											
1	Dietary	203,938	42,092	9,774	255,804		255,804	5,724	261,528			1
2	Food Purchase		298,466		298,466	(34,456)	264,010	(20)	263,990			2
3	Housekeeping	246,058	55,256		301,314		301,314	(4,340)	296,974			3
4	Laundry		6,512	30,545	37,057		37,057	(418)	36,639			4
5	Heat and Other Utilities			140,104	140,104		140,104	2,983	143,087			5
6	Maintenance	121,888		78,213	200,101		200,101	21,698	221,799			6
7	Other (specify):*							1,945	1,945			7
8	TOTAL General Services	571,884	402,326	258,636	1,232,846	(34,456)	1,198,390	27,572	1,225,962			8
	B. Health Care and Programs											
9	Medical Director			6,900	6,900		6,900		6,900			9
10	Nursing and Medical Records	1,077,957	34,368	22,224	1,134,549		1,134,549	25,115	1,159,664			10
10a	Therapy							3,399	3,399			10a
11	Activities	271,690	13,309	17,732	302,731		302,731		302,731			11
12	Social Services	516,590	15,499		532,089		532,089	16,637	548,726			12
13	CNA Training											13
14	Program Transportation			1,216	1,216		1,216		1,216			14
15	Other (specify):*							6,648	6,648			15
16	TOTAL Health Care and Programs	1,866,237	63,176	48,072	1,977,485		1,977,485	51,799	2,029,284			16
	C. General Administration											
17	Administrative	101,773		12,000	113,773		113,773	55,617	169,390			17
18	Directors Fees											18
19	Professional Services			257,531	257,531	(3,500)	254,031	(189,899)	64,132			19
20	Dues, Fees, Subscriptions & Promotions			55,260	55,260		55,260	(9,001)	46,259			20
21	Clerical & General Office Expenses	163,602	18,826	305,475	487,903		487,903	(89,413)	398,490			21
22	Employee Benefits & Payroll Taxes			431,530	431,530	34,456	465,986	(4,936)	461,050			22
23	Inservice Training & Education			1,475	1,475		1,475		1,475			23
24	Travel and Seminar			1,158	1,158		1,158	4,900	6,058			24
25	Other Admin. Staff Transportation			637	637		637	(405)	232			25
26	Insurance-Prop.Liab.Malpractice			128,195	128,195		128,195	(659)	127,536			26
27	Other (specify):*							39,845	39,845			27
28	TOTAL General Administration	265,375	18,826	1,193,261	1,477,462	30,956	1,508,418	(193,951)	1,314,467			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,703,496	484,328	1,499,969	4,687,793	(3,500)	4,684,293	(114,580)	4,569,713			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Grasmere Place #0044271 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	D. Ownership											
30	Depreciation			121,932	121,932		121,932	328,194	450,126			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,576	46,576		46,576	552,376	598,952			32
33	Real Estate Taxes					3,500	3,500	212,821	216,321			33
34	Rent-Facility & Grounds			1,032,000	1,032,000		1,032,000	(1,026,784)	5,216			34
35	Rent-Equipment & Vehicles			9,023	9,023		9,023	1,397	10,420			35
36	Other (specify):*							48,538	48,538			36
37	TOTAL Ownership			1,209,531	1,209,531	3,500	1,213,031	116,542	1,329,573			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			118,260	118,260		118,260		118,260			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,703,496	484,328	2,827,760	6,015,584		6,015,584	1,963	6,017,547			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	44,791	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(8,060)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,874)	21		24
25	Fund Raising, Advertising and Promotional	(5,589)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(236,346)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (276,098)		\$	30

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)	278,060		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 278,060		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,963		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.

		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Gramercy Place
 ID# 0044271
 Report Period Beginning: 01/01/06
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Rental Income	\$ (30)	6	1
2 Jury Duty Income	(12)	19	2
3 Misc. Income	(43,176)	21	3
4 Theft Loss	(362)	21	4
5 Collection Expense	(18)	21	5
6 C/P/E Dues	(3,078)	20	6
7 Building Company - Audit Fee	(8,920)	19	7
8 Building Company - Licenses & Fees	(650)	20	8
9 Non-Monthly Expense	(180,000)	21	9
10			10
11			11
12			12
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96			96
97			97
98			98
99			99
100			100
101 Total	(236,346)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			626				5,115		(17)			5,724	1
2	Food Purchase	(20)											(20)	2
3	Housekeeping									(4,340)			(4,340)	3
4	Laundry									(418)			(418)	4
5	Heat and Other Utilities			2,855			128						2,983	5
6	Maintenance	(30)	9,962	4,331	7,402		84			(51)			21,698	6
7	Other (specify):*				1,070			875					1,945	7
8	TOTAL General Services	(50)	9,962	7,812	8,472		212	5,990		(4,825)			27,572	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(120)						27,395		(2,160)			25,115	10
10a	Therapy							3,399					3,399	10a
11	Activities													11
12	Social Services				4,086			12,551					16,637	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				548			6,100					6,648	15
16	TOTAL Health Care and Programs	(120)			4,634			49,445		(2,160)			51,799	16
	C. General Administration													
17	Administrative			2,788	6,185			46,644					55,617	17
18	Directors Fees													18
19	Professional Services	(8,920)	8,920	(69,596)			(120,303)						(189,899)	19
20	Fees, Subscriptions & Promotions	(17,377)	650	7,674			52						(9,001)	20
21	Clerical & General Office Expenses	(294,422)		16,034	175,810		39	13,147		(21)			(89,413)	21
22	Employee Benefits & Payroll Taxes					(2,418)			(2,518)				(4,936)	22
23	Inservice Training & Education													23
24	Travel and Seminar			4,844			56						4,900	24
25	Other Admin. Staff Transportation			(405)									(405)	25
26	Insurance-Prop.Liab.Malpractice			(688)			29						(659)	26
27	Other (specify):*				27,143	4,557		8,145					39,845	27
28	TOTAL General Administration	(320,719)	9,570	(39,349)	209,138	2,139	(120,127)	67,936	(2,518)	(21)			(193,951)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(320,889)	19,532	(31,537)	222,244	2,139	(119,915)	123,371	(2,518)	(7,007)			(114,580)	29

STATE OF ILLINOIS

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	44,791	269,244	13,780			379						328,194	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		518,973	32,319			1,084						552,376	32
33	Real Estate Taxes		210,212	2,360			249						212,821	33
34	Rent-Facility & Grounds		(1,032,000)	5,216									(1,026,784)	34
35	Rent-Equipment & Vehicles			1,397									1,397	35
36	Other (specify):*		48,538										48,538	36
37	TOTAL Ownership	44,791	14,967	55,072			1,712						116,542	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(276,098)	34,499	23,535	222,244	2,139	(118,203)	123,371	(2,518)	(7,007)			1,963	45

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 Rent	\$ 1,032,000	Grasmere Real Estate, LLC	100.00%	\$	\$ (1,032,000)	1
2	V	32 Interest	2,153			521,126	518,973	2
3	V	19 Audit Fees				8,920	8,920	3
4	V	20 Licenses & Fees				650	650	4
5	V	6 R&M				9,962	9,962	5
6	V	36 Amortization				2,260	2,260	6
7	V	33 Real Estate Tax				210,212	210,212	7
8	V	36 MIP Insurance				46,278	46,278	8
9	V	30 Depreciation				269,244	269,244	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,034,153			\$ 1,068,652	\$ * 34,499	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/06Ending: 12/31/06

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		4 Amount	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			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 626	626	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	2,855	2,855	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	4,331	4,331	17	
18	V								18	
19	V	17	Administration		Care Centers, Inc.	100.00%	2,788	2,788	19	
20	V	19	Professional Fees	90,746	Care Centers, Inc.	100.00%	21,150	(69,596)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	7,674	7,674	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	16,034	16,034	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	4,844	4,844	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	(688)	(688)	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	13,780	13,780	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	32,319	32,319	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,360	2,360	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,216	5,216	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,397	1,397	29	
30	V	25	Bus Reimbursement	405	Care Centers, Inc.	100.00%		(405)	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			\$ 91,151			\$ 114,686	\$ * 23,535	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	06	Maintenance Salary	Care Centers, Inc.	100.00%	7,402	7,402	15	
16	V	07	Emp. Ben. - Gen. Serv.	Care Centers, Inc.	100.00%	1,070	1,070	16	
17	V	10	Nursing Salary	Care Centers, Inc.	100.00%			17	
18	V	10a	Rehab Salary	Care Centers, Inc.	100.00%			18	
19	V	12	Social Service Salary	Care Centers, Inc.	100.00%	4,086	4,086	19	
20	V	15	Emp. Ben. - Healthcare	Care Centers, Inc.	100.00%	548	548	20	
21	V	17	Administration Salary	Care Centers, Inc.	100.00%	6,185	6,185	21	
22	V	21	Office Salary	Care Centers, Inc.	100.00%	175,810	175,810	22	
23	V	27	Emp. Ben. - Gen. Admin.	Care Centers, Inc.	100.00%	27,143	27,143	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		\$			\$ 222,244	\$ * 222,244	39	

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

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/06Ending: 12/31/06

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	06 Maintenance Salary		Care Centers, Inc.	100.00%			15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%			16
17	V							17
18	V							18
19	V							19
20	V							20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%			21
22	V	21 Office Salary	16,119	Care Centers, Inc.	100.00%	16,119		22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	4,557	4,557	23
24	V							24
25	V	22 Employee Benefits	2,418				(2,418)	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		\$ 18,537			\$ 20,676	\$ * 2,139	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/06Ending: 12/31/06

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	19	Professional Fees	\$ 120,852	Care Centers Clinical, Inc.	100.00%	\$ 549	\$ (120,303)	15
16	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	52	52	16
17	V	21	Office and Clerical		Care Centers Clinical, Inc.	100.00%	39	39	17
18	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	56	56	18
19	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	379	379	19
20	V	32	Interest		Care Centers Clinical, Inc.	100.00%	1,084	1,084	20
21	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	128	128	21
22	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	84	84	22
23	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	29	29	23
24	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	249	249	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		\$ 120,852				\$ 2,649	\$ * (118,203)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	01	Dietary Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 5,115	\$ 5,115	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	875	875	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	27,395	27,395	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,399	3,399	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	12,551	12,551	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	6,100	6,100	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	46,644	46,644	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	13,147	13,147	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	8,145	8,145	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		\$				\$ 123,371	\$ * 123,371	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 124,363	\$ 124,363	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	126,881	CCS EMPLOYEE BENEFIT GROUP	100.00%		(126,881)	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			\$ 126,881			\$ 124,363	\$ * (2,518)	39

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

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/06Ending: 12/31/06

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	01 Dietary	\$ 210	Xcel Supply, LLC	100.00%	\$ 193	\$ (17)	15
16	V	03 Housekeeping	53,511	Xcel Supply, LLC	100.00%	49,172	(4,340)	16
17	V	04 Laundry	5,150	Xcel Supply, LLC	100.00%	4,733	(418)	17
18	V	06 Repairs & Maintenance	630	Xcel Supply, LLC	100.00%	579	(51)	18
19	V	10 Nursing	26,637	Xcel Supply, LLC	100.00%	24,477	(2,160)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office	258	Xcel Supply, LLC	100.00%	237	(21)	23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 86,397			\$ 79,390	\$ * (7,007)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning: 01/01/06

Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning: 01/01/06

Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/06 Ending: 12/31/06

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		See Attached	1.55	3.36%	Alloc Salary	\$ 2,537	17-7	1
2	Gale Rothner	Relative	Administrative		See Attached	1.63	4.66%	Alloc Salary	3,624	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	2.56	4.66%	Alloc Salary	6,206	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,367		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Patient Days	1,592,658	31	\$ 13,468	\$ 73,999	\$ 626	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	73,999	2,855	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	73,999	4,331	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	73,999	2,788	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	73,999	21,150	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	73,999	7,674	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	73,999	16,034	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	73,999	4,844	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	73,999	(688)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	73,999	13,780	11
12	32	Interest	Patient Days	1,592,658	31	695,586	73,999	32,319	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	73,999	2,360	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	73,999	5,216	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	73,999	1,397	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 114,686	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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		Patient Days	1,592,658	31			73,999		1
2	06	Maintenance Salary	1,592,658	31	159,318	159,318	73,999	7,402	2
3	07	Emp. Ben. - Gen. Serv.	1,592,658	31	23,038		73,999	1,070	3
4	10	Nursing Salary	1,592,658	31			73,999		4
5	10a	Rehab Salary	1,592,658	31			73,999		5
6	12	Social Service Salary	1,592,658	31	87,938	87,938	73,999	4,086	6
7	15	Emp. Ben. - Healthcare	1,592,658	31	11,794		73,999	548	7
8	17	Administration Salary	1,592,658	31	133,122	133,122	73,999	6,185	8
9	21	Office Salary	1,592,658	31	3,783,895	3,783,895	73,999	175,810	9
10	27	Emp. Ben. - Gen. Admin.	1,592,658	31	584,195		73,999	27,143	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				\$ 4,783,299	\$ 4,164,272		\$ 222,244	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	06	Maintenance Salary	Direct Allocation	26	366,540	366,540			1
2	07	Emp. Ben. - Gen. Serv.	Direct Allocation	26	60,795				2
3									3
4									4
5									5
6									6
7									7
8	21	Office Salary	Direct Allocation	23	418,249	418,249		16,119	8
9	27	Emp. Ben. - Gen. Admin.	Direct Allocation	23	70,744			4,557	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				\$ 916,329	\$ 784,790		\$ 20,676	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 73,999	\$ 549	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	73,999	52	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	73,999	39	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	73,999	56	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	73,999	379	5
6	32	Interest	Patient Days	1,592,658	30	23,321	73,999	1,084	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	73,999	128	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	73,999	84	8
9	26	Insurance	Patient Days	1,592,658	30	623	73,999	29	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	73,999	249	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					\$ 57,020	\$	\$ 2,649	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary Salary	Patient Days	1,592,658	30	110,093	110,093	73,999	5,115	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	73,999	875	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		73,999	27,395	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	73,999	3,399	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	73,999	12,551	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		73,999	6,100	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		73,999	46,644	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	73,999	13,147	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		73,999	8,145	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					\$ 2,655,265	\$ 755,172		\$ 123,371	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/06

Ending: 12/31/06

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 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		124,363	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				\$	\$		124,363	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	01	Dietary						\$ 193	1
2	03	Housekeeping						49,172	2
3	04	Laundry						4,733	3
4	06	Repairs & Maintenance						579	4
5	10	Nursing						24,477	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees, Subscriptions & Prom							8
9	21	Clerical & General Office						237	9
10	22	Employee Benefits							10
11	24	Seminars & Education							11
12	39	Ancillary							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				\$	\$		\$ 79,390	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HUD		X	Mortgage	\$71,078.00	1/26/99	\$ 9,518,795	\$ 9,208,654		\$ 521,126	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Diawa		X	Line of Credit				205,673		46,576	6									
7	Allocation from Care Centers		X							33,403	7									
8	See Supplemental Schedule										8									
9	TOTAL Facility Related				\$71,078.00		\$ 9,518,795	\$ 9,414,327		\$ 601,105	9									
B. Non-Facility Related*																				
10	Interest Income (Bldg Co)									(2,153)	10									
11											11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		(2,153)	14									
15	TOTALS (line 9+line14)						\$ 9,518,795	\$ 9,414,327		\$ 598,952	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 46,278 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

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

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

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/06

Ending: 12/31/06

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 202,100	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.)		\$ 203,721	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,621	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 211,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 3,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 216,321	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	116,897	8
	2002	118,227	9
	2003	188,330	10
	2004	192,513	11
	2005	201,112	12
<u>2006 Accrual = 2005 Tax \$201,112 x 1.05 = \$211,200 (rounded)</u>			
<u>Allocation from Care Centers \$2,609</u>			

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-214-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>197,538.89</u>	\$ <u>197,538.89</u>
2. <u>14-17-214-002-000</u>	<u>Long Term Care Property</u>	\$ <u>1,786.64</u>	\$ <u>1,786.64</u>
3. <u>14-17-214-003-000</u>	<u>Long Term Care Property</u>	\$ <u>1,786.64</u>	\$ <u>1,786.64</u>
4. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>116,388.47</u>	\$ <u>2,314.14</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>317,500.64</u>	\$ <u>203,426.31</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning:

01/01/06 Ending:

12/31/06

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>Facility</u>		<u>1999</u>	<u>\$ 800,000</u>	1
2	<u>Allocation - Care Centers</u>			<u>16,304</u>	2
3	TOTALS			\$ 816,304	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1999	83,114		20	3,793	3,793	27,541	9
10	Various			2000	251,874		20	12,726	12,726	85,055	10
11	Various			2001	59,759		20	2,991	2,991	16,860	11
12	Various			2002	147,991		20	14,151	14,151	64,319	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		6,154,018	269,244		188,173	(81,071)	1,431,142	67
68		63,988	1,812		2,651	839	10,558	68
69			121,932			(121,932)		69
70		\$ 6,760,744	\$ 392,988		\$ 224,485	\$ (168,503)	\$ 1,635,475	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,760,744	\$ 392,988		\$ 224,485	\$ (168,503)	\$ 1,635,475	1
2	Radiators Repairs	2003	1,043		20	52	52	209	2
3	Tiles	2003	823		20	41	41	165	3
4	Elevator Repair	2003	1,235		20	62	62	242	4
5	Elevator Repair	2003	4,297		20	215	215	824	5
6	New Shower Base	2003	1,203		20	60	60	231	6
7	Tiles	2003	544		20	27	27	104	7
8	Ceiling Tiles	2003	825		20	41	41	158	8
9	Repair Rooms From Water Damage	2003	12,500		20	625	625	2,344	9
10	Repair Rooms From Water Damage	2003	1,750		20	88	88	321	10
11	Install Relief Valve	2003	700		20	35	35	120	11
12	Leasehold Improvements	2003	1,375		20	69	69	235	12
13	Leasehold Improvements	2003	1,131		20	57	57	189	13
14	Leasehold Improvements	2003	703		20	35	35	117	14
15	Leasehold Improvements	2003	575		20	29	29	96	15
16	Paint	2003	947		20	47	47	154	16
17	Repair Elevator Door	2004	715		20	71	71	214	17
18	Vinal Tread	2004	587		20	59	59	176	18
19	Locks & Door Knobs	2004	715		20	72	72	215	19
20	Rebuild Boiler	2004	6,791		20	679	679	2,037	20
21	Reconnect Pipes	2004	15,297		20	1,530	1,530	4,589	21
22	Pilot Repair	2004	1,241		20	124	124	372	22
23	New Pedestal, Lavatory & Faucet	2004	735		20	74	74	221	23
24	Steam Piping Work	2004	6,207		20	621	621	1,810	24
25	Burner Repair & Parts	2004	1,271		20	127	127	371	25
26	Kitchen	2004	2,788		20	279	279	813	26
27	3 Toilet Bowls & Tanks	2004	590		20	118	118	344	27
28	Repair Electrical Service Boxes	2004	1,378		20	138	138	390	28
29	Two New Toilets -- Labor & Materials	2004	1,118		20	112	112	317	29
30	Water Piping	2004	844		20	84	84	239	30
31	Piping	2004	2,197		20	220	220	622	31
32	Boiler Repair	2004	1,840		20	184	184	521	32
33	Boiler Repair	2004	8,764		20	876	876	2,483	33
34	TOTAL (lines 1 thru 33)		\$ 6,843,473	\$ 392,988		\$ 231,336	\$ (161,652)	\$ 1,656,718	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,843,473	\$ 392,988		\$ 231,336	\$ (161,652)	\$ 1,656,718	1
2	Replace Motor On Pump	2004	671		20	67	67	190	2
3	Lock & Key Repairs	2004	828		20	83	83	235	3
4	Installed New Compressor	2004	750		20	75	75	206	4
5	Repaired Steam Leaks	2004	4,027		20	403	403	1,107	5
6	Toilet Bowls	2004	892		20	89	89	238	6
7	Sales Tax	2004	181		20	18	18	48	7
8	Metal Hinge Covers	2004	643		20	64	64	171	8
9	3 New Pilot Assemblies On Boiler	2004	1,203		20	120	120	311	9
10	New Circuit Breaker For Elevator	2004	331		20	33	33	80	10
11	Cubicle Curtains	2004	1,603		20	160	160	347	11
12	Cubicle Curtains	2004	1,340		20	134	134	290	12
13	Cubicle Curtains	2004	1,340		20	134	134	290	13
14	Paint	2004	1,819		20	91	91	273	14
15	Paint	2004	1,574		20	79	79	184	15
16	North Entry Center Near Elevator	2005	3,088		20	309	309	437	16
17	North Hallway, Pair Of Fire Doors	2005	5,045		20	505	505	715	17
18	Window Replacement	2005	25,200		20	2,520	2,520	3,360	18
19	Fire Escape Repairs	2005	8,950		20	895	895	1,119	19
20	Elevator Repairs	2006	3,215		20	214	214	214	20
21	Elevator Repairs	2006	2,322		20	135	135	135	21
22	Elevator Repairs	2006	814		20	47	47	47	22
23	Floor Tiles	2006	2,556		20	128	128	128	23
24	Plumbing Repairs	2006	1,829		20	76	76	76	24
25	Piping Replacement	2006	2,108		20	88	88	88	25
26	Plumbing Repairs	2006	1,657		20	69	69	69	26
27	Pipe Repair In Boiler Room	2006	9,800		20	408	408	408	27
28	Floor Repairs	2006	1,696		20	71	71	71	28
29	Hot And Cold Plumbing Pipes	2006	43,717		20	1,456	1,456	1,456	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		1
2									2
3									3
4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2									2
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		1
2									2
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		1
2									2
3									3
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2									2
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		1
2									2
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2								2
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12K, Carried Forward	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		1
2									2
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2								2
3								3
4								4
5								5
6								6
7								7
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2									2
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28									28
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
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23								23
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28								28
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,972,672	\$ 392,988		\$ 239,807	\$ (153,181)	\$ 1,669,011	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	216		1999	1964	\$ 5,578,000	\$	35	\$ 159,371	\$ 159,371	\$ 1,261,687	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Grasmere Real Estate		1999		301,871		20	15,094	15,094	132,788	9
10	Grasmere Real Estate (see attached)		2003		109,953		20	5,498	5,498	21,148	10
11	Grasmere Real Estate (see attached)		2004		24,653		20	1,233	1,233	3,337	11
12	Grasmere Real Estate (see attached)		2005		103,707		20	5,185	5,185	10,390	12
13	Grasmere Real Estate (see attached)		2006		35,834		20	1,792	1,792	1,792	13
14											14
15	Grasmere Real Estate Book Depreciation					269,244			(269,244)		15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	6,154,018	\$	269,244	\$	188,173	\$	(81,071)	\$	1,431,142	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06 Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocation -	Care Center Clinical	2002	2002	\$ 2,144	\$ 55	39	\$ 55	\$	\$ 236	4
5	Allocation -	Care Centers Inc.	2002	2002	20,324	521	39	521		2,237	5
6											6
7											7
8											8
Improvement Type**											
9	Allocation -	Care Center Clinical		2002	1,771	74	20	89	15	398	9
10	Allocation -	Care Center Clinical		2003	2,087	40	20	104	64	365	10
11	Allocation -	Care Center Clinical		2005	104	5	20	5		8	11
12											12
13	Allocation -	Care Centers Inc.		2002	16,789	698	20	839	141	3,778	13
14	Allocation -	Care Centers Inc.		2003	19,786	376	20	989	613	3,462	14
15	Allocation -	Care Centers Inc.		2005	983	43	20	49	6	74	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 63,988	\$ 1,812		\$ 2,651	\$ 839	\$ 10,558	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
71	Purchased in Prior Years	\$ 1,832,792	\$ 11,737	\$ 199,678	\$ 187,941	10	\$ 1,283,125	71
72	Current Year Purchases	11,644	68	5,049	4,981	10	5,049	72
73	Fully Depreciated Assets	9,957				10	9,957	73
74								74
75	TOTALS	\$ 1,854,393	\$ 11,805	\$ 204,727	\$ 192,922		\$ 1,298,131	75

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	
76	Facility	ESCORT	2001	\$ 8,270	\$	\$ 827	\$ 827	5	\$ 4,342	76
77	Facility	VOLKSWAGEN NEW BEETLE	2002	11,329		1,887	1,887	5	10,385	77
78		Alloc. Care Center Clinical	2005	2,032	138	138		5	138	78
79		Alloc. Care Centers Inc.		33,411	406	2,742	2,336	5	23,902	79
80	TOTALS			\$ 55,042	\$ 544	\$ 5,594	\$ 5,050		\$ 38,767	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 9,698,411	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 405,337	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 450,128	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 44,791	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,005,909	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning: 01/01/06

Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Care Centers				5,216			5
6								6
7	TOTAL				\$ 5,216			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 10,420

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	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): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,000	\$ 96,249	1
2	Cash-Patient Deposits	39,914	39,914	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,729,105	1,729,105	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,455	76,274	6
7	Other Prepaid Expenses	14,323	14,323	7
8	Accounts Receivable (owners or related parties)	52,881	52,881	8
9	Other(specify): <u>See Attached Schedule</u>		560,939	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,886,678	\$ 2,569,685	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	752,353	1,409,396	15
16	Equipment, at Historical Cost	187,090	1,771,556	16
17	Accumulated Depreciation (book methods)	(557,770)	(3,354,615)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	198	812,194	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 381,871	\$ 7,016,531	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,268,549	\$ 9,586,216	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 311,849	\$ 364,730	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,505	18,505	28
29	Short-Term Notes Payable	205,673	205,673	29
30	Accrued Salaries Payable	180,802	180,802	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,074	12,074	31
32	Accrued Real Estate Taxes(Sch.IX-B)		211,200	32
33	Accrued Interest Payable		43,204	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 728,903	\$ 1,036,188	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,208,654	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,208,654	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 728,903	\$ 10,244,842	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,539,646	\$ (658,626)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,268,549	\$ 9,586,216	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,219,201	1
2	Restatements (describe):		2
3	Interest Income	(149,517)	3
4	R&M	1,380	4
5	Depreciation	47,948	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,119,012	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,085,634	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	(665,000)	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)	\$ 420,634	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,539,646	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/06Ending: 12/31/06**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,060,579	1
2	Discounts and Allowances for all Levels	(4,266)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,056,313	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	30	16
17	Sale of Drugs	1,579	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,609	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	43,296	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 43,296	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,101,218	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,232,846	31
32	Health Care	1,977,485	32
33	General Administration	1,477,462	33
B. Capital Expense			
34	Ownership	1,209,531	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	118,260	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,015,584	40
41	Income before Income Taxes (line 30 minus line 40)**	1,085,634	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,085,634	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,794	2,156	\$ 62,321	\$ 28.91	1
2	Assistant Director of Nursing	1,753	2,166	61,616	28.45	2
3	Registered Nurses	1,739	1,851	44,202	23.88	3
4	Licensed Practical Nurses	15,069	16,496	335,811	20.36	4
5	CNAs & Orderlies	54,486	59,497	551,433	9.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,802	1,984	39,185	19.75	9
10	Activity Assistants	7,538	8,545	76,996	9.01	10
11	Social Service Workers	28,078	31,061	516,590	16.63	11
12	Dietician	1,758	1,980	26,062	13.16	12
13	Food Service Supervisor	1,905	2,213	26,617	12.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,904	5,435	60,778	11.18	15
16	Dishwashers	10,545	11,429	90,481	7.92	16
17	Maintenance Workers	9,865	10,976	121,888	11.10	17
18	Housekeepers	25,807	28,299	246,058	8.69	18
19	Laundry					19
20	Administrator	1,902	2,169	101,773	46.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,706	12,041	163,602	13.59	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	2,113	2,149	22,574	10.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	28,167	28,507	155,509	5.46	33
34	TOTAL (lines 1 - 33)	209,931	228,954	\$ 2,703,496 *	\$ 11.81	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	222	\$ 9,774	01-03	35
36	Medical Director	monthly	6,900	09-03	36
37	Medical Records Consultant	monthly	5,031	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,956	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	707	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Art Therapist Consultant</u>	341	17,025	11-03	47
48					48
49	TOTAL (lines 35 - 48)	578	\$ 42,393		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	15	\$ 832	10-03	50
51	Licensed Practical Nurses	388	13,405	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	403	\$ 14,237		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

Report Period Beginning: 01/01/06 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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8													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. ICLTC \$10,886
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 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 X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 118,260
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 34,456 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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. \$ _____
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT