

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 0044271

**Facility Name:** Grasmere Place

**Address:** 4621 North Sheridan 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:** 2/1/1999

**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
<b>IRS Exemption Code</b> _____	<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 01/01/07 to 12/31/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____
	(Type or Print Name) _____ (Date) _____
	(Title) _____
<b>Paid Preparer</b>	(Signed) _____ (Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; 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: 01/01/07 Ending: 12/31/07

## 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 bedsN/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			
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>74,373</u>	<u>335</u>		<u>74,708</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>74,373</u>	<u>335</u>		<u>74,708</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 94.76%

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

3,020 (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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Grasmere Place      #      0044271      Report Period Beginning:      01/01/07      Ending:      12/31/07

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	215,092	41,668	9,690	266,450		266,450	4,738	271,188		1
2	Food Purchase		295,291		295,291		295,291	371	295,662		2
3	Housekeeping	247,225	47,953		295,178		295,178	(3,128)	292,050		3
4	Laundry		6,021	30,196	36,217		36,217	(414)	35,803		4
5	Heat and Other Utilities			155,589	155,589		155,589	2,944	158,533		5
6	Maintenance	135,459		94,481	229,940		229,940	27,143	257,083		6
7	Other (specify):*							1,447	1,447		7
8	<b>TOTAL General Services</b>	<b>597,776</b>	<b>390,933</b>	<b>289,956</b>	<b>1,278,665</b>		<b>1,278,665</b>	<b>33,100</b>	<b>1,311,765</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,129,597	39,085	7,724	1,176,406		1,176,406	31,932	1,208,338		10
10a	Therapy							3,322	3,322		10a
11	Activities	278,498	12,888	19,325	310,711		310,711		310,711		11
12	Social Services	563,444	16,452		579,896		579,896	9,539	589,435		12
13	CNA Training										13
14	Program Transportation			520	520		520		520		14
15	Other (specify):*							6,090	6,090		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,971,539</b>	<b>68,425</b>	<b>34,769</b>	<b>2,074,733</b>		<b>2,074,733</b>	<b>50,883</b>	<b>2,125,616</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	116,649		31,492	148,141		148,141	73,702	221,843		17
18	Directors Fees										18
19	Professional Services			275,780	275,780	(14,791)	260,989	(200,380)	60,609		19
20	Dues, Fees, Subscriptions & Promotions			47,187	47,187		47,187	(2,686)	44,501		20
21	Clerical & General Office Expenses	175,846	21,769	285,240	482,855		482,855	(45,888)	436,967		21
22	Employee Benefits & Payroll Taxes			476,510	476,510		476,510	(194)	476,316		22
23	Inservice Training & Education			3,339	3,339		3,339		3,339		23
24	Travel and Seminar			3,997	3,997		3,997	1,701	5,698		24
25	Other Admin. Staff Transportation			1,942	1,942		1,942	1,762	3,704		25
26	Insurance-Prop.Liab.Malpractice			128,547	128,547		128,547	1,805	130,352		26
27	Other (specify):*							38,542	38,542		27
28	<b>TOTAL General Administration</b>	<b>292,495</b>	<b>21,769</b>	<b>1,254,034</b>	<b>1,568,298</b>	<b>(14,791)</b>	<b>1,553,507</b>	<b>(131,636)</b>	<b>1,421,871</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,861,810</b>	<b>481,127</b>	<b>1,578,759</b>	<b>4,921,696</b>	<b>(14,791)</b>	<b>4,906,905</b>	<b>(47,653)</b>	<b>4,859,252</b>		<b>29</b>

\*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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			78,869	78,869		78,869	224,131	303,000		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			3,655	3,655		3,655	472,385	476,040		32
33	Real Estate Taxes					14,791	14,791	202,328	217,119		33
34	Rent-Facility & Grounds			1,032,000	1,032,000		1,032,000	(1,028,400)	3,600		34
35	Rent-Equipment & Vehicles			8,864	8,864		8,864	481	9,345		35
36	Other (specify):*							48,007	48,007		36
37	<b>TOTAL Ownership</b>			1,123,388	1,123,388	14,791	1,138,179	(81,068)	1,057,111		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										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	<b>TOTAL Special Cost Centers</b>			118,260	118,260		118,260		118,260		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,861,810	481,127	2,820,407	6,163,344		6,163,344	(128,721)	6,034,623		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:

01/01/07

Ending:

12/31/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(36,638)	30		9
10	Interest and Other Investment Income	(88,786)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	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	(300)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(92,516)	21		24
25	Fund Raising, Advertising and Promotional	(7,953)	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	(166,219)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (392,425)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	263,704		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 263,704		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (128,721)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Gramercy Place ID# 0044271  
 Report Period Beginning: 01/01/07  
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Miscellaneous Income	\$ (2,931)	21	1
2 Burglary Income	(52)	10	2
3 Patient Clothing	(181)	10	3
4 Theft Loss	(4,875)	21	4
5 Collection Expense	(23)	21	5
6 Non-Allowable Expense	(153,568)	21	6
7 C/OPD Dues	(2,570)	20	7
8 Prior Year Seminar Expense	(86)	24	8
9 Prior Year Legal Fees	(500)	19	9
10 Annual Report	(250)	20	10
11 Non-Care Depreciation	(944)	30	11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(166,219)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary			312	4,424	2							4,738	1
2	Food Purchase	(13)		384									371	2
3	Housekeeping			586	59			(3,773)					(3,128)	3
4	Laundry							(414)					(414)	4
5	Heat and Other Utilities			2,793	151								2,944	5
6	Maintenance		13,995	13,161	19			(32)					27,143	6
7	Other (specify):*			1,027	420								1,447	7
8	<b>TOTAL General Services</b>	<b>(13)</b>	<b>13,995</b>	<b>18,263</b>	<b>5,073</b>	<b>2</b>		<b>(4,219)</b>					<b>33,100</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(233)			34,367	(68)		(2,134)					31,932	10
10a	Therapy				3,322								3,322	10a
11	Activities													11
12	Social Services				9,539								9,539	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,090								6,090	15
16	<b>TOTAL Health Care and Programs</b>	<b>(233)</b>			<b>53,318</b>	<b>(68)</b>		<b>(2,134)</b>					<b>50,883</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			13,329	60,369	4							73,702	17
18	Directors Fees													18
19	Professional Services	(500)		(85,267)	(114,613)								(200,380)	19
20	Fees, Subscriptions & Promotions	(10,773)		8,050	37								(2,686)	20
21	Clerical & General Office Expenses	(254,152)		196,217	15,626	6	(3,585)						(45,888)	21
22	Employee Benefits & Payroll Taxes							(194)					(194)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(386)		1,362	725								1,701	24
25	Other Admin. Staff Transportation			1,762									1,762	25
26	Insurance-Prop.Liab.Malpractice			1,786	19								1,805	26
27	Other (specify):*			28,279	10,262	1							38,542	27
28	<b>TOTAL General Administration</b>	<b>(265,811)</b>		<b>165,518</b>	<b>(27,575)</b>	<b>11</b>	<b>(3,585)</b>	<b>(194)</b>					<b>(131,636)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(266,057)</b>	<b>13,995</b>	<b>183,781</b>	<b>30,816</b>	<b>(55)</b>	<b>(3,585)</b>	<b>(6,548)</b>					<b>(47,653)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(37,582)	237,085	22,772	956		900						224,131	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(88,786)	512,844	42,968	4,119	1	1,239						472,385	32
33	Real Estate Taxes		198,770	3,333	225								202,328	33
34	Rent-Facility & Grounds		(1,032,000)	3,600									(1,028,400)	34
35	Rent-Equipment & Vehicles			474	7								481	35
36	Other (specify):*		48,007										48,007	36
37	<b>TOTAL Ownership</b>	<b>(126,368)</b>	<b>(35,294)</b>	<b>73,147</b>	<b>5,307</b>	<b>1</b>	<b>2,139</b>						<b>(81,068)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(392,425)</b>	<b>(21,299)</b>	<b>256,928</b>	<b>36,123</b>	<b>(54)</b>	<b>(1,446)</b>	<b>(6,548)</b>					<b>(128,721)</b>	<b>45</b>

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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 Company

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	2,317			515,161	512,844	2
3	V	36 MIP Insurance				45,747	45,747	3
4	V	33 Real Estate Tax				198,770	198,770	4
5	V	6 Repairs & Maintenan				13,995	13,995	5
6	V	36 Amortization				2,260	2,260	6
7	V	30 Depreciation				237,085	237,085	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,034,317			\$ 1,013,018	\$ * (21,299)	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: 01/01/07Ending: 12/31/07

## 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%	\$ 312	\$ 312	15	
16	V	02	Food		Care Centers, Inc.	100.00%	384	384	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	586	586	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	2,793	2,793	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	4,606	4,606	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	2,790	2,790	20	
21	V	19	Professional Fees	99,994	Care Centers, Inc.	100.00%	14,727	(85,267)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	8,050	8,050	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	23,329	23,329	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	1,362	1,362	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,762	1,762	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,786	1,786	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	22,772	22,772	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	42,968	42,968	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,333	3,333	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,600	3,600	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	474	474	31	
32	V	06	Maintenance		Care Centers, Inc.	100.00%	8,555	8,555	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,027	1,027	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	10,539	10,539	34	
35	V	21	Office and Clerical		Care Centers, Inc.	100.00%	172,888	172,888	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	28,279	28,279	36	
37	V	22	Employee Benefits		Care Centers, Inc.	100.00%			37	
38	V								38	
39	Total			\$ 99,994			\$ 356,922	\$ * 256,928	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: 01/01/07Ending: 12/31/07

## 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	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 59	\$ 59	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	151	151	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	19	19	17	
18	V	19	Professional Fees	117,131	Care Centers Clinical, Inc.	100.00%	2,518	(114,613)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	37	37	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	147	147	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	725	725	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	19	19	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	956	956	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	4,119	4,119	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	225	225	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	7	7	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	4,424	4,424	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	420	420	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	34,367	34,367	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,322	3,322	30	
31	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	9,539	9,539	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	6,090	6,090	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	60,369	60,369	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	15,479	15,479	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	10,262	10,262	35	
36	V	22	Employee Benefits		Care Centers Clinical, Inc.	100.00%			36	
37	V								37	
38	V								38	
39	Total			\$ 117,131			\$ 153,254	\$ * 36,123	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: 01/01/07Ending: 12/31/07

## 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	\$	Care Centers Health Systems, Inc.	100.00%	\$ 2	\$ 2	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%			17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%			18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%			19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%			20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1	1	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%			23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%			24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	1	1	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%			27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%			28
29	V	01 Dietary		Care Centers Health Systems, Inc.	100.00%			29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing	101	Care Centers Health Systems, Inc.	100.00%	33	(68)	32
33	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary		Care Centers Health Systems, Inc.	100.00%			35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	4	4	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	5	5	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1	1	38
39	Total		\$ 101			\$ 47	\$ *	(54) 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: 01/01/07Ending: 12/31/07

## 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 Repairs	\$	Vent Lease, LLC.	100.00%	\$		15
16	V	21 Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30 Depreciation		Vent Lease, LLC.	100.00%			17
18	V	32 Interest		Vent Lease, LLC.	100.00%			18
19	V	30 Depreciation		Vent Lease, LLC.	100.00%	900	900	19
20	V	32 Interest		Vent Lease, LLC.	100.00%	1,239	1,239	20
21	V	21 Office and Clerical	3,585	Vent Lease, LLC.	100.00%		(3,585)	21
22	V	39 Ancillary		Vent Lease, LLC.	100.00%			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		\$ 3,585			\$ 2,139	\$ * (1,446)	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: 01/01/07Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	46,786	Xcel Supply, LLC	100.00%	43,013	(3,773)	16
17	V	4 Laundry	5,131	Xcel Supply, LLC	100.00%	4,717	(414)	17
18	V	6 Repairs & Maintenance	400	Xcel Supply, LLC	100.00%	368	(32)	18
19	V	10 Nursing	26,369	Xcel Supply, LLC	100.00%	24,242	(2,127)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	2,405	Xcel Supply, LLC	100.00%	2,211	(194)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	10 Ancillary	92	Xcel Supply, LLC	100.00%	85	(7)	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		\$ 81,184			\$ 74,636	\$ * (6,548)	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 Benefits Group	100.00%	\$ 110,575	\$ 110,575	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	110,575	CCS Employee Benefits Group	100.00%		(110,575)	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			\$ 110,575			\$ 110,575	\$ *	39

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

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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: 01/01/07

Ending: 12/31/07

**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: 01/01/07

Ending: 12/31/07

**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: 01/01/07 Ending: 12/31/07

## 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	1.53	4.59%	Mgmt Fees	\$ 26,492	17-3	1
2	Mark Steinberg	Relative	Administrative		See Attached	2.52	4.58%	Alloc Salary	6,182	17-7	2
3	Adam Vales	Shareholder	Clerical	6.71	See Attached	0.68	1.70%	Alloc Salary	952	22-7	3
4	Kim Rudolph	Shareholder	Clerical	1.85	See Attached	0.6	1.71%	Alloc Salary	524	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 34,150		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: 01/01/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	1,625,640	33	\$ 6,823	\$ 74,362	\$ 312	1
2	02	Food	Patient Days	1,625,640	33	8,403	74,362	384	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	74,362	586	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	74,362	2,793	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	74,362	4,606	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	74,362	2,790	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	74,362	14,727	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	74,362	8,050	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	74,362	23,329	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	74,362	1,362	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	74,362	1,762	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	74,362	1,786	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	74,362	22,772	13
14	32	Interest	Patient Days	1,625,640	33	939,326	74,362	42,968	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	74,362	3,333	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	74,362	3,600	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	74,362	474	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	8,555	18
19	06	Maintenance	Direct Allocation			456,812	456,812		19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	74,362	1,027	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	10,539	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	172,888	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346		23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	74,362	28,279	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 356,922	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Care Center 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

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	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 74,362	\$ 59	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	74,362	151	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	74,362	19	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	74,362	2,518	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	74,362	37	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	74,362	147	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	74,362	725	7	
8	26	Insurance	Patient Days	1,625,640	32	409	74,362	19	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	74,362	956	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	74,362	4,119	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	74,362	225	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	74,362	7	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	74,362	4,424	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	74,362	420	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	74,362	34,367	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	74,362	3,322	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	74,362	9,539	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	74,362	6,090	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	74,362	60,369	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	74,362	15,479	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	74,362	10,262	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22	
23	12	Social Service Salary	Direct Allocation			8,845	8,845		23	
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			24	
25	TOTALS					\$ 3,374,561	\$ 2,809,547	\$ 153,254	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

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	01	Dietary	Gross Billable Income	4,431,674	33	94,358	101	2	1
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	101		2
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	101		3
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	101		4
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	101		5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	101		6
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	101	1	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	101		8
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	101		9
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	101		10
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	101	1	11
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	101		12
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	101		13
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	101		14
15	01	Dietary	Direct Billable Income	341,879	33	112,243			15
16	02	Food	Direct Billable Income	25	33	8			16
17	03	Housekeeping	Direct Billable Income	29	33	10			17
18	10	Nursing	Direct Billable Income	69,616	33	22,856	101	33	18
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298			21
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	101	4
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	101	5
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873		101	1
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 47	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271 Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Vent Lease, LLC  
 Street Address 2201 W. Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

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	Repairs	Direct Billing	892,186	27	\$ 35,557			1
2	21	Office and Clerical	Direct Billing	892,186	27	44			2
3	30	Depreciation	Direct Billing	892,186	27	280,000			3
4	32	Interest	Direct Billing	892,186	27	23,404			4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	74,362	900	5
6	32	Interest	Patient Days	1,625,640	33	27,081	74,362	1,239	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					\$ 385,762	\$	\$ 2,139	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271 Report Period Beginning: 01/01/07

Ending: 12/31/07

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 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

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	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					43,013	2
3	4	Laundry	Direct Allocation					4,717	3
4	6	Repairs & Maintenance	Direct Allocation					368	4
5	10	Nursing	Direct Allocation					24,242	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					2,211	10
11	24	Seminars & Education	Direct Allocation						11
12	10	Ancillary	Direct Allocation					85	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				\$	\$		\$ 74,636	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271 Report Period Beginning: 01/01/07

Ending: 12/31/07

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, Illinois 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		\$	\$		\$ 110,575	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				\$	\$		\$ 110,575	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	HUD		X	Mortgage	\$71,078.00	1/26/99	\$ 9,518,795	\$ 9,099,949			\$ 515,161	1					
2	GMAC		X	Auto	\$412.01			18,952	2011	5.9000	93	2					
3												3					
4												4					
5	See Supplemental Schedule											5					
<b>Working Capital</b>																	
6	Diawa		X	Line of Credit							3,562	6					
7												7					
8	See Supplemental Schedule										48,327	8					
9	TOTAL Facility Related				\$71,490.01		\$ 9,518,795	\$ 9,118,901			\$ 567,143	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income										(88,786)	10					
11	Interest Income (Bldg Co)										(2,317)	11					
12												12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related						\$	\$			\$ (91,103)	14					
15	TOTALS (line 9+line14)						\$ 9,518,795	\$ 9,118,901			\$ 476,040	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 45,747 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8	Alloc - Care Centers Inc.		X						\$ 42,968	8										
9	Alloc - Care Centers Health System		X						1	9										
10	Alloc - Care Centers Clinical		X						4,119	10										
11	Alloc - Vent Lease		X						1,239	11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<u>211,200</u>	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.)			\$	<u>203,528</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(7,672)</u>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>210,000</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<u>14,791</u>	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>217,119</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	<u>118,227</u>	8			
2003	<u>188,330</u>	9			
2004	<u>192,513</u>	10			
2005	<u>201,112</u>	11			
2006	<u>199,970</u>	12			
<u>2007 Accrual: \$199,970 x 1.05 = \$210,000 (rounded)</u>					
<u>Allocation from : Care Centers Inc. \$3,333; Care Centers Clinical \$225</u>					
			<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$			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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-214-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>186,165.56</u>	\$ <u>186,165.56</u>
2. <u>14-17-214-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,902.36</u>	\$ <u>6,902.36</u>
3. <u>14-17-214-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,902.36</u>	\$ <u>6,902.36</u>
4. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>118,409.42</u>	\$ <u>3,460.50</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>318,379.70</u>	\$ <u>203,430.78</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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:

01/01/07 Ending:

12/31/07

**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>18,265</u>	2
3	<b>TOTALS</b>			<b>\$ 818,265</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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
		<b>Improvement Type**</b>									
9	Various		1999		83,114		20	3,793	3,793	31,331	9
10	Various		2000		251,874		20	12,726	12,726	97,777	10
11	Various		2001		59,759		20	2,991	2,991	19,846	11
12	Various		2002		147,991		20	13,987	13,987	78,301	12
13	Various		2003		29,651		20	1,483	1,483	6,989	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
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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:

01/01/07

Ending:

12/31/07

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
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54								54
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60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		6,176,387	237,085		189,291	(47,794)	1,619,920	67
68		102,672	5,396		5,396		33,801	68
69			77,925			(77,925)		69
70		\$ 6,851,448	\$ 320,406		\$ 229,667	\$ (90,739)	\$ 1,887,965	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Grasmere Place

# 0044271

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,851,448	\$ 320,406		\$ 229,667	\$ (90,739)	\$ 1,887,965	1
2	Repair Elevator Door	2004	715		20	71	71	286	2
3	Vinal Tread	2004	587		20	59	59	235	3
4	Locks & Door Knobs	2004	715		20	72	72	286	4
5	Rebuild Boiler	2004	6,791		20	679	679	2,717	5
6	Reconnect Pipes	2004	15,297		20	1,530	1,530	6,119	6
7	Pilot Repair	2004	1,241		20	124	124	496	7
8	New Pedestal, Lavatory & Faucet	2004	735		20	74	74	294	8
9	Steam Piping Work	2004	6,207		20	621	621	2,431	9
10	Burner Repair & Parts	2004	1,271		20	127	127	498	10
11	Kitchen	2004	2,788		20	279	279	1,092	11
12	3 Toilet Bowls & Tanks	2004	590		20	118	118	462	12
13	Repair Electrical Service Boxes	2004	1,378		20	138	138	528	13
14	Two New Toilets -- Labor & Materials	2004	1,118		20	112	112	429	14
15	Water Piping	2004	844		20	84	84	324	15
16	Piping	2004	2,197		20	220	220	842	16
17	Boiler Repair	2004	1,840		20	184	184	705	17
18	Boiler Repair	2004	8,764		20	876	876	3,359	18
19	Replace Motor On Pump	2004	671		20	67	67	257	19
20	Lock & Key Repairs	2004	828		20	83	83	317	20
21	Installed New Compressor	2004	750		20	75	75	281	21
22	Repaired Steam Leaks	2004	4,027		20	403	403	1,510	22
23	Toilet Bowls	2004	892		20	89	89	327	23
24	Sales Tax	2004	181		20	18	18	66	24
25	Metal Hinge Covers	2004	643		20	64	64	236	25
26	3 New Pilot Assemblies On Boiler	2004	1,203		20	120	120	431	26
27	New Circuit Breaker For Elevator	2004	331		20	33	33	113	27
28	Cubicle Curtains	2004	1,603		20	160	160	508	28
29	Cubicle Curtains	2004	1,340		20	134	134	424	29
30	Cubicle Curtains	2004	1,340		20	134	134	424	30
31	Paint	2004	1,819		20	91	91	364	31
32	Paint	2004	1,574		20	79	79	262	32
33	North Entry Center Near Elevator	2005	3,088		20	309	309	746	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,924,816	\$ 320,406		\$ 236,894	\$ (83,512)	\$ 1,915,334	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:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,924,816	\$ 320,406		\$ 236,894	\$ (83,512)	\$ 1,915,334	1
2	North Hallway, Pair Of Fire Doors	2005	5,045		20	505	505	1,219	2
3	Window Replacement	2005	25,200		20	2,520	2,520	5,880	3
4	Fire Escape Repairs	2005	8,950		20	895	895	2,014	4
5	Elevator Repairs	2006	3,215		20	322	322	536	5
6	Elevator Repairs	2006	2,322		20	232	232	368	6
7	Elevator Repairs	2006	814		20	81	81	129	7
8	Floor Tiles	2006	2,556		20	256	256	383	8
9	Plumbing Repairs	2006	1,829		20	183	183	259	9
10	Piping Replacement	2006	2,108		20	211	211	299	10
11	Plumbing Repairs	2006	1,657		20	166	166	235	11
12	Pipe Repair In Boiler Room	2006	9,800		20	980	980	1,388	12
13	Floor Repairs	2006	1,696		20	170	170	240	13
14	Hot And Cold Plumbing Pipes	2006	43,717		20	2,916	2,916	3,279	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
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10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
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8									8
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

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	\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
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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)	\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12L, Carried Forward</b>		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,033,725	\$ 320,406		\$ 246,331	\$ (74,075)	\$ 1,931,563	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:

01/01/07

Ending:

12/31/07

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	\$ 1,420,658	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Grasmere Real Estate			1999	301,871		20	15,094	15,094	147,882	9
10	Grasmere Real Estate (see attached)			2003	109,953		20	5,498	5,498	26,646	10
11	Grasmere Real Estate (see attached)			2004	24,653		20	1,233	1,233	4,570	11
12	Grasmere Real Estate (see attached)			2005	103,707		20	5,185	5,185	15,463	12
13	Grasmere Real Estate (see attached)			2006	35,834		20	1,792	1,792	3,583	13
14	Grasmere Real Estate (see attached)			2007	22,369		20	1,118	1,118	1,118	14
15											15
16	Grasmere Real Estate (book depreciation)					237,085			(237,085)		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:

01/01/07

Ending:

12/31/07

**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				
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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	<b>TOTAL (lines 4 thru 69)</b>	\$	6,176,387	\$	237,085	\$	189,291	\$	(47,794)	\$	1,619,920	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:

01/01/07

Ending:

12/31/07

**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 Centers Inc.		2002	2002	\$ 20,370	\$ 522	39	\$ 522		\$ 2,764	4
5	Allocation - Care Centers Inc. - Hillside		1996	1996	34,540	886	39	886		9,779	5
6	Allocation - Care Centers Health Systems		2002	2002	1		39				6
7	Allocation - Care Centers Clinical		2002	2002	2,110	54	39	54		286	7
8											8
	<b>Improvement Type**</b>										
9	Allocation - Care Centers Inc.			2002	16,827	1,538	20	1,538		7,704	9
10	Allocation - Care Centers Inc.			2003	19,830	1,812	20	1,812		9,079	10
11	Allocation - Care Centers Inc.			2005	985	105	20	105		250	11
12	Allocation - Care Centers Inc.			2007	210	14	20	14		14	12
13	Allocation - Care Centers Inc.			1996	582		20			582	13
14	Allocation - Care Centers Inc.			1997	3,317	107	20	107		1,578	14
15											15
16	Allocation - Care Centers Health Systems			2003	1		20				16
17											17
18	Allocation - Care Centers Clinical			2002	1,743	159	20	159		798	18
19	Allocation - Care Centers Clinical			2003	2,054	188	20	188		941	19
20	Allocation - Care Centers Clinical			2005	102	11	20	11		26	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:

01/01/07

Ending:

12/31/07

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		
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58								58		
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61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	102,672	\$	5,396	\$	5,396	\$	33,801	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: 01/01/07 Ending: 12/31/07

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	\$ 468,001	\$ 16,301	\$ 48,781	\$ 32,480	10	\$ 1,330,414	71
72	Current Year Purchases	1,706	216	216		10	443	72
73	Fully Depreciated Assets	1,389,929		4,299	4,299	10	1,389,929	73
74								74
75	TOTALS	\$ 1,859,636	\$ 16,517	\$ 53,296	\$ 36,779		\$ 2,720,786	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		2007 PONTIAC VIBE - AUTO	2007	\$ 17,535	\$	\$ 658	\$ 658	5	\$ 658	76
77		Allocation from Care Centers	1900	41,717		2,715	2,715	5	32,388	77
78										78
79			various		2,715		(2,715)			79
80	TOTALS			\$ 59,252	\$ 2,715	\$ 3,373	\$ 658		\$ 33,046	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)		\$ 9,770,878	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 339,638	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 303,000	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (36,638)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,685,395	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	ESCORT - 2001	\$ 8,270	\$	\$ 8,270	86
87	VOLKSWAGEN NEW BEETLE - 2002	11,329	944	11,329	87
88					88
89					89
90					90
91	TOTALS	\$ 19,599	\$ 944	\$ 19,599	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Inc.				3,600			5
6								6
7	TOTAL				\$ 3,600			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 9,345 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.

**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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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): <a href="#">See Supplemental</a>									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as 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: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,000	\$ 99,884	1
2	Cash-Patient Deposits	34,374	34,374	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,666,045	1,666,045	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,664	166,164	6
7	Other Prepaid Expenses	6,216	6,216	7
8	Accounts Receivable (owners or related parties)	47,725	47,725	8
9	Other(specify): <u>See Attached Schedule</u>	1,103,863	1,694,966	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,998,887	\$ 3,715,374	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	752,380	1,428,233	15
16	Equipment, at Historical Cost	204,625	1,796,948	16
17	Accumulated Depreciation (book methods)	(600,476)	(3,634,406)	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>	2,890	812,626	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 359,419	\$ 6,781,401	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,358,306	\$ 10,496,775	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 435,873	\$ 483,598	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,668	20,668	28
29	Short-Term Notes Payable	18,952	18,952	29
30	Accrued Salaries Payable	199,430	199,430	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,623	9,623	31
32	Accrued Real Estate Taxes(Sch.IX-B)		210,000	32
33	Accrued Interest Payable		42,694	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 684,546	\$ 984,965	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,099,949	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 9,099,949	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 684,546	\$ 10,084,914	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,673,760	\$ 411,861	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,358,306	\$ 10,496,775	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,539,649	1
2	Restatements (describe):		2
3	<u>Repairs &amp; Maintenance</u>	27	3
4	<u>Depreciation</u>	36,163	4
5	<u>Pension Expense</u>	(3,090)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,572,749	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,101,011	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,101,011	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,673,760	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,172,587	1
2	Discounts and Allowances for all Levels	(2,695)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,169,892	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,360	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	334	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,694	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	88,786	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 88,786	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,983	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,983	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,264,355	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,278,665	31
32	Health Care	2,074,733	32
33	General Administration	1,568,298	33
<b>B. Capital Expense</b>			
34	Ownership	1,123,388	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	118,260	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,163,344	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,101,011	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,101,011	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: 01/01/07

Ending:

12/31/07

**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	1,393	1,673	\$ 52,546	\$ 31.41	1
2	Assistant Director of Nursing	1,805	2,090	62,544	29.93	2
3	Registered Nurses	3,267	3,447	85,041	24.67	3
4	Licensed Practical Nurses	14,366	15,788	349,831	22.16	4
5	CNAs & Orderlies	52,795	57,468	555,402	9.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,907	2,205	45,248	20.52	9
10	Activity Assistants	6,945	7,692	70,361	9.15	10
11	Social Service Workers	30,095	33,451	563,444	16.84	11
12	Dietician	1,685	1,968	26,830	13.63	12
13	Food Service Supervisor	1,805	2,088	26,285	12.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,490	6,366	69,145	10.86	15
16	Dishwashers	10,461	11,129	92,832	8.34	16
17	Maintenance Workers	10,166	11,243	135,459	12.05	17
18	Housekeepers	24,802	27,124	247,225	9.11	18
19	Laundry					19
20	Administrator	1,837	2,139	116,649	54.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,271	12,510	175,846	14.06	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	2,129	2,176	24,233	11.14	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	29,167	29,390	162,889	5.54	33
34	TOTAL (lines 1 - 33)	211,386	229,947	\$ 2,861,810 *	\$ 12.45	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	\$ 9,690	01-03	35
36	Medical Director	monthly	7,200	09-03	36
37	Medical Records Consultant	monthly	4,034	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	montly	3,146	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	16	800	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Art Therapist</u>	371	18,525	11-03	47
48					48
49	TOTAL (lines 35 - 48)	609	\$ 43,395		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses	16	544	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 544		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

# 0044271

Report Period Beginning: 01/01/07

Ending: 12/31/07

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Celeste Jensen	Administrator	0	\$ 116,649	Workers' Compensation Insurance	\$ 64,972	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	33,282	Advertising: Employee Recruitment	5,669		
				FICA Taxes	213,422	Health Care Worker Background Check	1,756		
				Employee Health Insurance	125,111	(Indicate # of checks performed <u>97</u> )			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	25,096		
				Chicago Employer Tax	4,389	Licenses & Fees	2,898		
				Employee Physicals	35	Advertising & Promotion	7,953		
				Pension Expense	25,928	See Supplemental Schedule	8,087		
				Other Employee Welfare	6,324	Less: Public Relations Expense	( )		
				Holiday Expense	2,853	Non-allowable advertising	(7,953)		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 116,649				\$ 476,316			\$ 44,501		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Nathan Langsner			\$ 5,000				Out-of-State Travel	\$	
Management Fees - Eric Rothner			26,492						
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		3,611
\$ 31,492				\$			Allocated - Care Centers Inc.		1,362
C. Professional Services							Allocated - Care Centers Clinical		725
Vendor/Payee	Type		Amount				Entertainment Expense		( )
Frost Ruttenberg & Rothblatt	Legal		\$ 14,250				(agree to Sch. V, line 24, col. 8)		
Care Centers Inc.	Home Office Expense		99,994				TOTAL		\$ 5,698
Care Centers Clinical	Home Office Expense		117,131						
Personnel Planners	Unemployment Consultant		1,494						
ADP, Inc.	Payroll Processing		10,776						
National Data Corporation	Data Processing		2,331						
Admiral Environmental Service	Water Certified Statement		250						
Allegiance	Employee Compliance		155						
HFG	Audit Fee / Line of Credit		5,573						
Prospect Resources	Natural Gas Procurement		700						
Various - See Attached	Legal		23,126						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL					
\$ 275,780				\$					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Grasmere Place

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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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. See Attached
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 578 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ \_\_\_\_\_ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT