

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>216</u>	Intermediate (ICF)	<u>216</u>	<u>78,840</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>216</u>	TOTALS	<u>216</u>	<u>78,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>70,481</u>	<u>1,210</u>		<u>71,691</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>70,481</u>	<u>1,210</u>		<u>71,691</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.93%

D. How many bed-hold days during this year were paid by the Department? 3,069 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/09 Ending: 12/31/09

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
	A. General Services										
1	Dietary	229,068	49,467	10,453	288,988		288,988	6,475	295,463		1
2	Food Purchase		324,234		324,234		324,234	730	324,964		2
3	Housekeeping	268,347	61,530		329,877		329,877	(4,758)	325,119		3
4	Laundry		11,029	33,308	44,337		44,337	(977)	43,360		4
5	Heat and Other Utilities			148,740	148,740		148,740	3,195	151,935		5
6	Maintenance	156,284		109,355	265,639		265,639	30,807	296,446		6
7	Other (specify):*							2,842	2,842		7
8	TOTAL General Services	653,699	446,260	301,856	1,401,815		1,401,815	38,315	1,440,130		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,297,868	51,908	3,504	1,353,280		1,353,280	38,533	1,391,813		10
10a	Therapy							2,396	2,396		10a
11	Activities	310,902	14,317	14,876	340,095		340,095		340,095		11
12	Social Services	606,701	13,180	4,260	624,141		624,141	12,889	637,030		12
13	CNA Training										13
14	Program Transportation			1,430	1,430		1,430		1,430		14
15	Other (specify):*							8,292	8,292		15
16	TOTAL Health Care and Programs	2,215,471	79,405	33,670	2,328,546		2,328,546	62,110	2,390,656		16
	C. General Administration										
17	Administrative	116,848		15,600	132,448		132,448	70,265	202,713		17
18	Directors Fees										18
19	Professional Services			305,016	305,016	(3,500)	301,516	(230,370)	71,146		19
20	Dues, Fees, Subscriptions & Promotions			46,536	46,536		46,536	(19,163)	27,373		20
21	Clerical & General Office Expenses	171,356	19,340	379,924	570,620		570,620	(114,749)	455,871		21
22	Employee Benefits & Payroll Taxes			501,453	501,453		501,453	(2,873)	498,580		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,240	10,240		10,240	1,503	11,743		24
25	Other Admin. Staff Transportation			421	421		421	537	958		25
26	Insurance-Prop.Liab.Malpractice			131,841	131,841		131,841	29,484	161,325		26
27	Other (specify):*							44,434	44,434		27
28	TOTAL General Administration	288,204	19,340	1,391,031	1,698,575	(3,500)	1,695,075	(220,932)	1,474,143		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,157,374	545,005	1,726,557	5,428,936	(3,500)	5,425,436	(120,507)	5,304,929		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Grasmere Place

#0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			68,074	68,074		68,074	219,155	287,229			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			642	642		642	515,928	516,570			32
33	Real Estate Taxes					3,500	3,500	207,374	210,874			33
34	Rent-Facility & Grounds			1,034,462	1,034,462		1,034,462	(1,026,965)	7,497			34
35	Rent-Equipment & Vehicles			5,904	5,904		5,904	3,555	9,459			35
36	Other (specify):*							44,594	44,594			36
37	TOTAL Ownership			1,109,082	1,109,082	3,500	1,112,582	(36,359)	1,076,223			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,068		23,068		23,068	(1,057)	22,011			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		23,068	118,260	141,328		141,328	(1,057)	140,271			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,157,374	568,073	2,953,899	6,679,346		6,679,346	(157,924)	6,521,422			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:

01/01/09

Ending:

12/31/09

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	(38,228)	30		9
10	Interest and Other Investment Income	(93,196)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(55)	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	(100)	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	(148,412)	21		24
25	Fund Raising, Advertising and Promotional	(2,511)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(198,705)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (486,207)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	328,283		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 328,283		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (157,924)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Revenue - Jury Duty	\$ (17)	10	1
2	Theft Loss	(1,202)	21	2
3	Collection Expense	(9)	21	3
4	COPE Dues	(6,668)	20	4
5	Prior Period Adjustment - Computer Expense	(177)	21	5
6	Alliance for Living PAC	(12,688)	20	6
7	Annual Report	(250)	20	7
8	Building Co. - Accounting	(10,000)	19	8
9	Building Co. - Licenses & Fees	(450)	20	9
10	Building Co. - Amortization	(2,260)	36	10
11	Non-Allowable Expense	(164,400)	21	11
12	Prior Period and Non-Allowable Legal Fees	(584)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(198,705)		49

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grasmere Place# 0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			353		6,122							6,475	1
2	Food Purchase	(55)		785									730	2
3	Housekeeping			732		81	(5,571)						(4,758)	3
4	Laundry						(977)						(977)	4
5	Heat and Other Utilities			3,003		192							3,195	5
6	Maintenance		14,608	4,661	11,419	25			94				30,807	6
7	Other (specify):*				1,954	888							2,842	7
8	TOTAL General Services	(55)	14,608	9,534	13,373	7,308	(6,547)		94				38,315	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)				41,673	(3,123)						38,533	10
10a	Therapy					2,396							2,396	10a
11	Activities													11
12	Social Services					12,889							12,889	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,292							8,292	15
16	TOTAL Health Care and Programs	(17)				65,250	(3,123)						62,110	16
	C. General Administration													
17	Administrative			3,439	12,467	54,359							70,265	17
18	Directors Fees													18
19	Professional Services	(10,584)	10,000	(112,227)		(117,564)			5				(230,370)	19
20	Fees, Subscriptions & Promotions	(22,567)	450	2,943		11							(19,163)	20
21	Clerical & General Office Expenses	(319,300)		24,086	187,515	12,190	(10)		(19,230)				(114,749)	21
22	Employee Benefits & Payroll Taxes				(2,790)	(83)							(2,873)	22
23	Inservice Training & Education													23
24	Travel and Seminar			92		1,411							1,503	24
25	Other Admin. Staff Transportation			537									537	25
26	Insurance-Prop.Liab.Malpractice		28,228	1,181		70			5				29,484	26
27	Other (specify):*				34,990	9,444							44,434	27
28	TOTAL General Administration	(352,451)	38,678	(79,949)	232,182	(40,162)	(10)		(19,220)				(220,932)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(352,523)	53,286	(70,415)	245,555	32,396	(9,681)		(19,126)				(120,507)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grasmere Place# 0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(38,228)	234,126	6,020		1,333			15,904				219,155	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(93,196)	501,658	88,489		16,106			2,871				515,928	32
33	Real Estate Taxes		204,157	2,902		315							207,374	33
34	Rent-Facility & Grounds		(1,032,000)	5,035									(1,026,965)	34
35	Rent-Equipment & Vehicles			3,555									3,555	35
36	Other (specify):*	(2,260)	46,854										44,594	36
37	TOTAL Ownership	(133,684)	(45,205)	106,001		17,754			18,775				(36,359)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(97)		(960)				(1,057)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(97)		(960)				(1,057)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(486,207)	8,081	35,586	245,555	50,150	(9,778)		(1,311)				(157,924)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Grasmere Real Estate, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,032,000	Grasmere Real Estate, LLC		\$	(1,032,000)	1
2	V	32 Interest	517	Grasmere Real Estate, LLC		502,175	501,658	2
3	V	19 Accounting		Grasmere Real Estate, LLC		10,000	10,000	3
4	V	20 Licenses & Fees		Grasmere Real Estate, LLC		450	450	4
5	V	36 MIP Expense		Grasmere Real Estate, LLC		44,594	44,594	5
6	V	33 Real Estate Taxes		Grasmere Real Estate, LLC		204,157	204,157	6
7	V	26 Insurance		Grasmere Real Estate, LLC		28,228	28,228	7
8	V	06 Repairs and Maintenance		Grasmere Real Estate, LLC		14,608	14,608	8
9	V	36 Amortization		Grasmere Real Estate, LLC		2,260	2,260	9
10	V	30 Depreciation		Grasmere Real Estate, LLC		234,126	234,126	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,032,517			\$ 1,040,598	\$ * 8,081	14

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

VII. RELATED PARTIES (continued)

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

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

1	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	\$	Extended Care Consulting, LLC	100.00%	\$ 353	\$	353	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	785		785	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	732		732	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	3,003		3,003	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,661		4,661	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,439		3,439	20
21	V	19 Professional Fees	127,100	Extended Care Consulting, LLC	100.00%	14,873		(112,227)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,943		2,943	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	24,086		24,086	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	92		92	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	537		537	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,181		1,181	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	6,020		6,020	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	88,489		88,489	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,902		2,902	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	5,035		5,035	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	3,555		3,555	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 127,100			\$ 162,686	\$ *	35,586	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	11,419	\$	11,419	15
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,954		1,954	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	12,467		12,467	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	187,515		187,515	20
21	V	21 Office and Clerical (Direct)	13,948	Extended Care Consulting, LLC	100.00%	13,948			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	32,083		32,083	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,907		2,907	23
24	V	22 Employee Benefits	2,790	Extended Care Consulting, LLC	100.00%			(2,790)	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		\$ 16,738			\$ 262,293	\$ *	245,555	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 81	\$	81	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	192		192	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	25		25	17
18	V	19 Professional Fees	119,237	Extended Care Clinical, LLC	100.00%	1,673		(117,564)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	11		11	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,422		1,422	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,411		1,411	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	70		70	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,333		1,333	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	16,106		16,106	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	315		315	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	6,122		6,122	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	888		888	27
28	V	10 Nursing Salary	416	Extended Care Clinical, LLC	100.00%	42,089		41,673	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	2,396		2,396	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	12,889		12,889	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,292		8,292	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	54,359		54,359	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	10,768		10,768	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,444		9,444	34
35	V	22 Employee Benefits	83	Extended Care Clinical, LLC	100.00%			(83)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 119,736			\$ 169,886	\$ *	50,150	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	<u>1 Dietary</u>	\$	<u>Xcel Supply, LLC</u>	100.00%	\$	\$	15
16	V	<u>3 Housekeeping</u>	60,660	<u>Xcel Supply, LLC</u>	100.00%	55,089	(5,571)	16
17	V	<u>4 Laundry</u>	10,638	<u>Xcel Supply, LLC</u>	100.00%	9,661	(977)	17
18	V	<u>6 Repairs & Maintenance</u>		<u>Xcel Supply, LLC</u>	100.00%			18
19	V	<u>10 Nursing</u>	34,011	<u>Xcel Supply, LLC</u>	100.00%	30,887	(3,123)	19
20	V	<u>11 Activities</u>		<u>Xcel Supply, LLC</u>	100.00%			20
21	V	<u>12 Social Service</u>		<u>Xcel Supply, LLC</u>	100.00%			21
22	V	<u>20 Dues, Fees And Subscriptions</u>		<u>Xcel Supply, LLC</u>	100.00%			22
23	V	<u>21 Office And Clerical</u>	111	<u>Xcel Supply, LLC</u>	100.00%	101	(10)	23
24	V	<u>22 Employee Benefits</u>		<u>Xcel Supply, LLC</u>	100.00%			24
25	V	<u>24 Seminars & Education</u>		<u>Xcel Supply, LLC</u>	100.00%			25
26	V	<u>39 Ancillary</u>	1,058	<u>Xcel Supply, LLC</u>	100.00%	961	(97)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 106,478			\$ 96,700	\$ * (9,778)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 146,318	\$ 146,318	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	146,318	CCS Employee Benefits Group	100.00%		(146,318)	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		\$ 146,318			\$ 146,318	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 94	\$ 94
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	5	5
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	8	8
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%		
19	V	26 Insurance		Vent Lease, LLC.	100.00%	5	5
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	246	246
21	V	32 Interest		Vent Lease, LLC.	100.00%	41	41
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	15,658	15,658
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	2,830	2,830
24	V	21 Office and Clerical	19,238	Vent Lease, LLC.	100.00%		(19,238)
25	V	39 Ancillary	960	Vent Lease, LLC.	100.00%		(960)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 20,198			\$ 18,887	\$ * (1,311)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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.

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.

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.

Facility Name & ID Number

Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.56	5.20%	Mgmt. Fees	\$ 15,600	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.87	5.20%	Alloc. Salary	8,676	17-7	2
3	Adam Vales	Shareholder	Clerical	6.68%	See Attached	0.85	6.71%	Alloc. Salary	1,535	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,811		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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

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

1	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	30	\$ 6,770	\$	71,691	\$ 353	1
2	02	Food	Patient Days	30	15,058		71,691	785	2
3	03	Housekeeping	Patient Days	30	14,059		71,691	732	3
4	05	Utilities	Patient Days	30	57,646		71,691	3,003	4
5	06	Maintenance	Patient Days	30	89,465		71,691	4,661	5
6	17	Administrative	Patient Days	30	66,000		71,691	3,439	6
7	19	Professional Fees	Patient Days	30	285,482		71,691	14,873	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		71,691	2,943	8
9	21	Office and Clerical	Patient Days	30	462,313		71,691	24,086	9
10	24	Seminar and Travel	Patient Days	30	1,768		71,691	92	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		71,691	537	11
12	26	Insurance	Patient Days	30	22,668		71,691	1,181	12
13	30	Depreciation	Patient Days	30	115,549		71,691	6,020	13
14	32	Interest	Patient Days	30	1,698,489		71,691	88,489	14
15	33	Real Estate Taxes	Patient Days	30	55,709		71,691	2,902	15
16	34	Rent - Building	Patient Days	30	96,636		71,691	5,035	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		71,691	3,555	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 162,686	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,376,056	30	219,177	219,177	71,691	11,419	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		71,691	1,954	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464			4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	71,691	12,467	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	71,691	187,515	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			13,948	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	71,691	32,083	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	71,691	2,907	9
10	22	Employee Benefits								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					\$ 5,530,203	\$ 4,838,529	\$	262,293	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

1	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	1,376,056	30	\$ 1,549	\$ 71,691	\$ 81	1
2	05	Utilities	Patient Days	1,376,056	30	3,693	71,691	192	2
3	06	Maintenance	Patient Days	1,376,056	30	477	71,691	25	3
4	19	Professional Fees	Patient Days	1,376,056	30	32,105	71,691	1,673	4
5	20	Dues and Subscriptions	Patient Days	1,376,056	30	213	71,691	11	5
6	21	Office & Clerical	Patient Days	1,376,056	30	27,296	71,691	1,422	6
7	24	Travel and Seminar	Patient Days	1,376,056	30	27,079	71,691	1,411	7
8	26	Insurance	Patient Days	1,376,056	30	1,342	71,691	70	8
9	30	Depreciation	Patient Days	1,376,056	30	25,586	71,691	1,333	9
10	32	Interest	Patient Days	1,376,056	30	309,136	71,691	16,106	10
11	33	Real Estate Taxes	Patient Days	1,376,056	30	6,053	71,691	315	11
12	01	Dietary Salary	Patient Days	1,376,056	30	117,506	71,691	6,122	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,376,056	30	17,040	71,691	888	13
14	10	Nursing Salary	Patient Days	1,376,056	30	799,889	71,691	41,673	14
15	10a	Rehab Salary	Patient Days	1,376,056	30	45,993	71,691	2,396	15
16	12	Social Service Salary	Patient Days	1,376,056	30	247,396	71,691	12,889	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,376,056	30	158,537	71,691	8,260	17
18	17	Administration Salary	Patient Days	1,376,056	30	1,043,375	71,691	54,359	18
19	21	Office Salary	Patient Days	1,376,056	30	206,680	71,691	10,768	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,376,056	30	181,271	71,691	9,444	20
21	10	Nursing Salary	Direct Allocation			494,488	71,691	416	21
22	12	Social Service Salary	Direct Allocation			196,033			22
23	15	Emp. Ben. - Healthcare	Direct Allocation			82,560		32	23
24									24
25	TOTALS					\$ 4,025,296	\$ 3,151,360	\$ 169,886	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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					55,089	2
3	4	Laundry	Direct Allocation					9,661	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					30,887	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					101	9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					961	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				\$	\$		\$ 96,700	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 146,318	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				\$	\$		\$ 146,318	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	821,185	26	\$ 80,807	\$ 960	\$ 94	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	960	5	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	960	8	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	960		4
5	26	Insurance	Direct Billing	821,185	26	4,573	960	5	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	960	246	6
7	32	Interest	Direct Billing	821,185	26	35,420	960	41	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	71,691	15,658	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	71,691	2,830	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					\$ 706,114	\$	\$ 18,887	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending: 12/31/09

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: 01/01/09 Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	HUD	X	Mortgage	\$71,078.00	01/26/99	\$ 9,518,795	\$ 8,863,333		\$ 502,175	1									
2	GMAC	X	Auto Loan	\$412.01			8,542		5.9000	642									
3										3									
4										4									
5	See Supplemental Schedule									5									
Working Capital																			
6										6									
7										7									
8	See Supplemental Schedule									8									
9	TOTAL Facility Related			\$71,490.01		\$ 9,518,795	\$ 8,871,875		\$ 502,817	9									
B. Non-Facility Related*																			
10	Interest Income								(93,196)	10									
11	Interest Income - Bldg. Co.								(517)	11									
12	Allocated from EC Consulting	X							88,489	12									
13	See Supplemental Schedule								18,977	13									
14	TOTAL Non-Facility Related					\$	\$		\$ 13,753	14									
15	TOTALS (line 9+line14)					\$ 9,518,795	\$ 8,871,875		\$ 516,570	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,594 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.)

Facility Name & ID Number

Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term											7								
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital											14								
	B. Non-Facility Related*																			
15	Allocated from EC Clinical		X				\$	\$			\$	16,106	15							
16	Allocated from Vent Lease		X									2,871	16							
17													17							
18													18							
19													19							
20	TOTAL Non-Facility Related											18,977	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.)

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.)

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

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>	<u>1</u>
2	<u>Allocated from EC Consulting/EC Clinical 2201 Main</u>			<u>19,120</u>	<u>2</u>
3	TOTALS			\$ 819,120	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1999	83,114		20	3,793	3,793	38,910	9
10	Various		2000	251,874		20	12,726	12,726	123,221	10
11	Various		2001	59,759		20	2,991	2,991	25,820	11
12	Various		2002	147,991		20	13,542	13,542	105,769	12
13	Various		2003	29,651		20	1,483	1,483	9,954	13
14	Various		2004	70,280		20	6,810	6,810	40,269	14
15	Various		2005	42,283		20	4,229	4,229	18,316	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	6,285,648	234,126		194,755	(39,371)	2,010,423	67
68	Related Party Allocations (Pages 12H & 12I)	75,652	5,167		5,167		31,474	68
69	Financial Statement Depreciation		68,074			(68,074)		69
70	TOTAL (lines 4 thru 69)	\$ 7,046,252	\$ 307,367		\$ 245,496	\$ (61,871)	\$ 2,404,156	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,046,252	\$ 307,367		\$ 245,496	\$ (61,871)	\$ 2,404,156	1
2	Elevator Repairs	2006	3,215		20	322	322	1,179	2
3	Elevator Repairs	2006	2,322		20	232	232	832	3
4	Elevator Repairs	2006	814		20	81	81	292	4
5	Floor Tiles	2006	2,556		20	256	256	895	5
6	Plumbing Repairs	2006	1,829		20	183	183	625	6
7	Piping Replacement	2006	2,108		20	211	211	720	7
8	Plumbing Repairs	2006	1,657		20	166	166	566	8
9	Pipe Repair In Boiler Room	2006	9,800		20	980	980	3,348	9
10	Floor Repairs	2006	1,696		20	170	170	579	10
11	Electrical Work	2008	3,000		20	300	300	350	11
12	Repaired Riser & Sewer	2008	10,572		20	1,057	1,057	1,145	12
13	Glass Doors	2009	2,850		20	71	71	71	13
14	New Water Line	2009	14,934		20	498	498	498	14
15	New Masterkey System	2009	6,924		20	115	115	115	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,110,529	\$ 307,367		\$ 250,138	\$ (57,229)	\$ 2,415,371	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,110,529	\$ 307,367		\$ 250,138	\$ (57,229)	\$ 2,415,371	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,110,529	\$ 307,367		\$ 250,138	\$ (57,229)	\$ 2,415,371	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,110,529	\$ 307,367		\$ 250,138	\$ (57,229)	\$ 2,415,371	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,110,529	\$ 307,367		\$ 250,138	\$ (57,229)	\$ 2,415,371	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,110,529	\$ 307,367		\$ 250,138	\$ (57,229)	\$ 2,415,371	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,110,529	\$ 307,367		\$ 250,138	\$ (57,229)	\$ 2,415,371	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:

01/01/09

Ending:

12/31/09

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	Building Company Information								1
2	Buildings:								2
3		1964	5,578,000		35	159,371	159,371	1,739,400	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Grasmere Real Estate	1999	301,871		20	15,094	15,094	178,070	9
10	Grasmere Real Estate (see attached)	2003	109,953		20	5,498	5,498	37,642	10
11	Grasmere Real Estate (see attached)	2004	24,653		20	1,233	1,233	7,034	11
12	Grasmere Real Estate (see attached)	2005	103,707		20	5,185	5,185	25,831	12
13	Exhaust Fan	2006	7,075		20	354	354	1,416	13
14	Vacuum Pump	2006	1,393		20	70	70	279	14
15	Window	2006	563		20	28	28	112	15
16	Gate	2006	5,700		20	285	285	1,140	16
17	Water Heater	2006	7,500		20	375	375	1,500	17
18	Elevator	2006	5,416		20	271	271	1,084	18
19	Boiler	2006	2,800		20	140	140	560	19
20	Plumbing	2006	45,784		20	2,289	2,289	8,064	20
21	Floor tiles	2006	1,045		20	52	52	209	21
22	Wall Paint	2006	532		20	27	27	107	22
23	Fire Alarm	2006	1,100		20	55	55	220	23
24	Metal Hinges-Panels	2006	643		20	32	32	128	24
25	Cubicle Curtains	2007	3,559		20	178	178	534	25
26	Piping	2007	15,832		20	792	792	2,376	26
27	Fire Doors	2007	2,978		20	149	149	447	27
28	Piping Repair	2008	7,309		20	365	365	730	28
29	Elevator Repair	2008	2,738		20	137	137	274	29
30	Boiler Repair	2008	9,826		20	491	491	982	30
31	Carpet	2009	11,000		20	550	550	550	31
32	Fire Escape Repairs	2009	9,160		20	458	458	458	32
33	Masonry Repairs	2009	2,810		20	141	141	141	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	USA Satellite & Cable	2009	9,620		20	481	481	481	2
3	Window Screen	2009	5,880		20	294	294	294	3
4	Boiler	2009	6,061		20	303	303	303	4
5	New Exterior Lights	2009	1,140		20	57	57	57	5
6									6
7									7
8	Grasmere Real Estate Book Depreciation			234,126			(234,126)		8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 6,285,648	\$ 234,126		\$ 194,755	\$ (39,371)	\$ 2,010,423	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main	2002	23,734	609	39	609		4,437	3
4	Allocated from Extended Care Clinical 2201 Main	2002	2,615	67	39	67		489	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	240	4	20	4		28	9
10	Allocated from Extended Care Consulting	2009	143	7	20	7		7	10
11									11
12	Allocated from Extended Care Consulting 2201 Main	2002	19,606	1,792	20	1,792		10,768	12
13	Allocated from Extended Care Consulting 2201 Main	2003	23,105	2,112	20	2,112		12,690	13
14	Allocated from Extended Care Consulting 2201 Main	2005	1,148	122	20	122		414	14
15	Allocated from Extended Care Consulting 2201 Main	2009	207	10	20	10		10	15
16									16
17	Allocated from Extended Care Clinical 2201 Main	2002	2,160	197	20	197		1,186	17
18	Allocated from Extended Care Clinical 2201 Main	2003	2,545	233	20	233		1,398	18
19	Allocated from Extended Care Clinical 2201 Main	2005	126	13	20	13		46	19
20	Allocated from Extended Care Clinical 2201 Main	2009	23	1	20	1		1	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

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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 75,652	\$ 5,167		\$ 5,167	\$ 31,474	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:

01/01/09

Ending:

12/31/09

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	\$ 327,170	\$ 16,648	\$ 32,105	\$ 15,457	10	\$ 1,259,135	71
72	Current Year Purchases	4,302	430	430		10	430	72
73	Fully Depreciated Assets	1,554,964				10	1,554,964	73
74								74
75	TOTALS	\$ 1,886,436	\$ 17,078	\$ 32,535	\$ 15,457		\$ 2,814,529	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	\$	\$ 3,544	\$ 3,544	5	\$ 9,265	76
77		Alloc. Extended Care Consult.	2009	16,753	262	262		5	15,968	77
78		Alloc. Extended Care Clinical	2009	3,745	749	749		5	2,206	78
79										79
80	TOTALS			\$ 38,033	\$ 1,011	\$ 4,555	\$ 3,544		\$ 27,439	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)	\$ 9,854,118	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 325,456	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 287,228	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (38,228)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,257,339	85

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

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

G. Construction-in-Progress

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

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

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

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	Storage Rental			2,462			5
6	Allocated from EC Consulting			5,035			6
7	TOTAL			\$ 7,497			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,459 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

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. _____/2009 \$ _____
13. _____/2010 \$ _____
14. _____/2011 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		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	Other (specify):									12
13	Other (specify): See Supplemental						23,068		23,068	13
14	TOTAL			\$		\$	23,068		\$ 23,068	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: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,000	\$ 100,081	1
2	Cash-Patient Deposits	89,220	89,220	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,097,209	2,097,209	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	202,126	227,931	6
7	Other Prepaid Expenses	11,414	11,414	7
8	Accounts Receivable (owners or related parties)	14,671	14,671	8
9	Other(specify): <u>See Attached Schedule</u>	560,998	1,128,447	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,976,638	\$ 3,668,973	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	746,947	1,521,026	15
16	Equipment, at Historical Cost	208,020	1,811,343	16
17	Accumulated Depreciation (book methods)	(737,967)	(4,245,302)	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>	296	805,512	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 217,296	\$ 6,270,579	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,193,934	\$ 9,939,552	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 467,969	\$ 468,170	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,368	23,368	28
29	Short-Term Notes Payable	8,542	8,542	29
30	Accrued Salaries Payable	144,997	144,997	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,411	2,411	31
32	Accrued Real Estate Taxes(Sch.IX-B)		211,700	32
33	Accrued Interest Payable		41,584	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	64,684	64,684	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 711,971	\$ 965,456	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,863,333	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,863,333	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 711,971	\$ 9,828,789	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,481,963	\$ 110,763	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,193,934	\$ 9,939,552	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,018,052	1
2	Restatements (describe):		2
3	Prior Year Dividends Booked in Late Journal Entry	(2,605,401)	3
4	Rounding	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,412,653	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,069,310	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)	\$ 1,069,310	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,481,963	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,655,381	1
2	Discounts and Allowances for all Levels	(9,675)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,645,706	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	244	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 244	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,493	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,493	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	93,196	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 93,196	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	17	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,748,656	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,401,815	31
32	Health Care	2,328,546	32
33	General Administration	1,698,575	33
B. Capital Expense			
34	Ownership	1,109,082	34
C. Ancillary Expense			
35	Special Cost Centers	23,068	35
36	Provider Participation Fee	118,260	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,679,346	40
41	Income before Income Taxes (line 30 minus line 40)**	1,069,310	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,069,310	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:

01/01/09

Ending:

12/31/09

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	1,901	2,167	\$ 84,523	\$ 39.00	1
2	Assistant Director of Nursing	1,816	2,134	69,612	32.62	2
3	Registered Nurses	3,625	3,955	114,904	29.05	3
4	Licensed Practical Nurses	15,700	17,392	397,518	22.86	4
5	CNAs & Orderlies	54,396	59,659	609,695	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,840	2,120	46,020	21.71	9
10	Activity Assistants	7,383	8,026	78,519	9.78	10
11	Social Service Workers	30,006	34,131	606,701	17.78	11
12	Dietician	1,478	1,740	25,153	14.46	12
13	Food Service Supervisor	2,049	2,432	31,337	12.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,711	4,275	53,398	12.49	15
16	Dishwashers	11,905	13,117	119,180	9.09	16
17	Maintenance Workers	9,607	11,124	156,284	14.05	17
18	Housekeepers	24,729	27,383	268,347	9.80	18
19	Laundry					19
20	Administrator	1,857	2,118	116,848	55.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,534	12,008	171,356	14.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,873	2,115	21,616	10.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	27,540	27,966	186,363	6.66	33
34	TOTAL (lines 1 - 33)	211,950	233,862	\$ 3,157,374 *	\$ 13.50	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	230	\$ 10,453	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,088	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	27	4,260	12-03	45
46	Other(specify)				46
47	<u>Art Therapist</u>	270	14,875	11-03	47
48	<u>See Attached - Extended Care Allocation</u>		416		48
49	TOTAL (lines 35 - 48)	526	\$ 42,692		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 116,848	Workers' Compensation Insurance	\$ 70,194	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	22,283	Advertising: Employee Recruitment	3,861	
				FICA Taxes	233,230	Health Care Worker Background Check		
				Employee Health Insurance	139,252	(Indicate # of checks performed <u>127</u>)	2,058	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		<u>IL Council On LTC</u>	10,476	
				<u>City Payroll Tax</u>	6,830	<u>IL Association of HFC</u>	2,592	
				<u>Employee Physicals</u>	105	<u>Dues & Subscriptions</u>	2,245	
				<u>Pension Expense</u>	21,924	<u>Licenses & Fees</u>	2,190	
				<u>Other Employee Welfare</u>	1,712	<u>See Supplemental Schedule</u>	2,954	
				<u>Holiday Expense</u>	3,050	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 498,580	\$ 27,371		
				TOTAL (agree to Schedule V, line 22, col.8)				
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other								
Description				Description			Description	
Amount				Line #			Amount	
Management Fees - Eric Rothner							Out-of-State Travel	
\$ 15,600							\$	
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 15,600				\$			10,240	
							Allocated from EC Consultin	
							92	
							Allocated from EC Clinical	
							1,411	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	
\$ 305,017							\$ 11,743	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/09

Ending:

12/31/09

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. ILCLTC - \$16,394; Alliance for Living \$12,960
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 868 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.