

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>71,597</u>	<u>378</u>		<u>71,975</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>71,597</u>	<u>378</u>		<u>71,975</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.29%

D. How many bed-hold days during this year were paid by the Department? 3,093 (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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	228,665	48,802	2,664	280,131		280,131	5,718	285,849		1
2	Food Purchase		321,280		321,280		321,280	504	321,784		2
3	Housekeeping	263,584	59,188		322,772		322,772	(2,780)	319,992		3
4	Laundry		11,303	38,772	50,075		50,075	(520)	49,555		4
5	Heat and Other Utilities			160,578	160,578		160,578	1,675	162,253		5
6	Maintenance	153,559		142,403	295,962		295,962	13,884	309,846		6
7	Other (specify):*							2,340	2,340		7
8	TOTAL General Services	645,808	440,573	344,417	1,430,798		1,430,798	20,821	1,451,619		8
	B. Health Care and Programs										
9	Medical Director			10,400	10,400		10,400		10,400		9
10	Nursing and Medical Records	1,390,419	52,625	11,204	1,454,248		1,454,248	33,225	1,487,473		10
10a	Therapy							5,147	5,147		10a
11	Activities	334,595	18,305	16,700	369,600		369,600		369,600		11
12	Social Services	623,608	16,822	3,520	643,950		643,950	3,683	647,633		12
13	CNA Training										13
14	Program Transportation			1,195	1,195		1,195		1,195		14
15	Other (specify):*							6,255	6,255		15
16	TOTAL Health Care and Programs	2,348,622	87,752	43,019	2,479,393		2,479,393	48,310	2,527,703		16
	C. General Administration										
17	Administrative	117,867		31,300	149,167		149,167	66,051	215,218		17
18	Directors Fees										18
19	Professional Services			346,762	346,762	(25,312)	321,450	(224,795)	96,655		19
20	Dues, Fees, Subscriptions & Promotions			27,658	27,658		27,658	2,903	30,561		20
21	Clerical & General Office Expenses	152,659	18,218	3,162,283	3,333,160		3,333,160	(2,914,690)	418,470		21
22	Employee Benefits & Payroll Taxes			555,370	555,370		555,370	(6,269)	549,101		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,252	8,252		8,252	1,953	10,205		24
25	Other Admin. Staff Transportation			1,539	1,539		1,539	951	2,490		25
26	Insurance-Prop.Liab.Malpractice			254,026	254,026		254,026	24,181	278,207		26
27	Other (specify):*							40,413	40,413		27
28	TOTAL General Administration	270,526	18,218	4,387,190	4,675,934	(25,312)	4,650,622	(3,009,302)	1,641,320		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,264,956	546,543	4,774,626	8,586,125	(25,312)	8,560,813	(2,940,171)	5,620,642		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:

01/01/10

Ending:

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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			56,143	56,143		56,143	207,769	263,912			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			157,584	157,584		157,584	344,466	502,050			32
33	Real Estate Taxes					25,312	25,312	113,679	138,991			33
34	Rent-Facility & Grounds			1,034,332	1,034,332		1,034,332	(1,032,000)	2,332			34
35	Rent-Equipment & Vehicles			23,960	23,960		23,960	(8,017)	15,943			35
36	Other (specify):*							43,967	43,967			36
37	TOTAL Ownership			1,272,019	1,272,019	25,312	1,297,331	(330,136)	967,195			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,609		1,609		1,609	(578)	1,031			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):*			148,700	148,700		148,700	(148,700)				43
44	TOTAL Special Cost Centers		1,609	266,960	268,569		268,569	(149,278)	119,291			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,264,956	548,152	6,313,605	10,126,713		10,126,713	(3,419,584)	6,707,129			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:

01/01/10

Ending:

12/31/10

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	547	30		9
10	Interest and Other Investment Income	(181,210)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(2,974)	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	(3,083,412)	21		24
25	Fund Raising, Advertising and Promotional	(990)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,200)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(161,960)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,431,216)		\$	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)	11,632		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 11,632		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,419,584)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty Income	\$ (17)	10	1
2				2
3	Collection Expense	(408)	21	3
4	Building Co. - Accounting	(10,000)	19	4
5	Building Co. - Filing Fees	(250)	21	5
6	Building Co. - Bank Charge	(75)	21	6
7	Building Co. - Amortization	(2,260)	36	7
8	Annual Report	(250)	20	8
9	Non-Allowable Expense	(148,700)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				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	(161,960)		49

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/10

Ending: 12/31/10

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:

01/01/10

Ending:

12/31/10

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			187		5,531							5,718	1
2	Food Purchase	(17)		521									504	2
3	Housekeeping			669		74		(3,523)					(2,780)	3
4	Laundry							(520)					(520)	4
5	Heat and Other Utilities			1,519		156							1,675	5
6	Maintenance			4,366	9,366	154		(2)					13,884	6
7	Other (specify):*				1,565	775							2,340	7
8	TOTAL General Services	(17)		7,262	10,931	6,690		(4,045)					20,821	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)				35,594		(2,352)					33,225	10
10a	Therapy					5,147							5,147	10a
11	Activities													11
12	Social Services					3,683							3,683	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,226	29						6,255	15
16	TOTAL Health Care and Programs	(17)				50,650	29	(2,352)					48,310	16
	C. General Administration													
17	Administrative			3,094	12,015	50,942							66,051	17
18	Directors Fees													18
19	Professional Services	(10,000)	10,000	(114,202)		(110,593)							(224,795)	19
20	Fees, Subscriptions & Promotions	(1,240)		3,923		220							2,903	20
21	Clerical & General Office Expenses	(3,088,319)	325	18,328	145,631	9,356		(11)					(2,914,690)	21
22	Employee Benefits & Payroll Taxes				(6,168)		(29)	(72)					(6,269)	22
23	Inservice Training & Education													23
24	Travel and Seminar			191		1,762							1,953	24
25	Other Admin. Staff Transportation			951									951	25
26	Insurance-Prop.Liab.Malpractice		22,936	1,044		201							24,181	26
27	Other (specify):*				32,252	8,161							40,413	27
28	TOTAL General Administration	(3,099,559)	33,261	(86,671)	183,730	(39,951)	(29)	(83)					(3,009,302)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,099,593)	33,261	(79,409)	194,661	17,389		(6,480)					(2,940,171)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grasmere Place# 0044271

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	547	200,516	5,640		1,066							207,769	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(181,210)	494,582	10,764		20,330							344,466	32
33	Real Estate Taxes		111,253	2,185		241							113,679	33
34	Rent-Facility & Grounds		(1,032,000)										(1,032,000)	34
35	Rent-Equipment & Vehicles			2,692						(10,709)			(8,017)	35
36	Other (specify):*	(2,260)	46,227										43,967	36
37	TOTAL Ownership	(182,923)	(179,422)	21,281		21,637				(10,709)			(330,136)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(62)		(516)			(578)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(148,700)											(148,700)	43
44	TOTAL Special Cost Centers	(148,700)						(62)		(516)			(149,278)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(3,431,216)	(146,161)	(58,128)	194,661	39,026		(6,541)		(11,225)			(3,419,584)	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	100.00%	\$	\$ (1,032,000)	1
2	V	32 Interest	534	Grasmere Real Estate, LLC	100.00%	495,116	494,582	2
3	V	19 Accounting		Grasmere Real Estate, LLC	100.00%	10,000	10,000	3
4	V	21 Bank Charges		Grasmere Real Estate, LLC	100.00%	75	75	4
5	V	36 MIP Expense		Grasmere Real Estate, LLC	100.00%	43,967	43,967	5
6	V	33 Real Estate Taxes		Grasmere Real Estate, LLC	100.00%	111,253	111,253	6
7	V	26 Insurance		Grasmere Real Estate, LLC	100.00%	22,936	22,936	7
8	V	21 Filing Fees		Grasmere Real Estate, LLC	100.00%	250	250	8
9	V	36 Amortization		Grasmere Real Estate, LLC	100.00%	2,260	2,260	9
10	V	30 Depreciation		Grasmere Real Estate, LLC	100.00%	200,516	200,516	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,032,534			\$ 886,373	\$ * (146,161)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 187	\$	187	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	521		521	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	669		669	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,519		1,519	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,366		4,366	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,094		3,094	20
21	V	19 Professional Fees	127,100	Extended Care Consulting, LLC	100.00%	12,898		(114,202)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,923		3,923	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	18,328		18,328	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	191		191	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	951		951	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,044		1,044	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	5,640		5,640	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	10,764		10,764	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,185		2,185	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	1,502			30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,692		2,692	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			\$ 70,474	\$ *	(58,128)	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%	9,366	\$	9,366	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%	1,565		1,565	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V	12 Admission (Direct)		Extended Care Consulting, LLC	100.00%				19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%				20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	12,015		12,015	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	145,631		145,631	22
23	V	21 Office and Clerical (Direct)	22,346	Extended Care Consulting, LLC	100.00%	22,346			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	26,343		26,343	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,909		5,909	25
26	V	22 Employee Benefits	6,168	Extended Care Consulting, LLC	100.00%			(6,168)	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		\$ 28,514			\$ 223,175	\$ *	194,661	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%	\$ 74	\$	74	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	156		156	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	154		154	17
18	V	19 Professional Fees	119,237	Extended Care Clinical, LLC	100.00%	8,644		(110,593)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	220		220	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	2,064		2,064	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,762		1,762	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	201		201	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,066		1,066	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	20,330		20,330	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	241		241	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	5,531		5,531	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	775		775	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	35,594		35,594	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	5,147		5,147	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	3,683		3,683	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,226		6,226	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	50,942		50,942	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	7,292		7,292	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	8,161		8,161	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 119,237			\$ 158,263	\$ *	39,026	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	01 Dietary Salary	\$	Extended Care Clinical, LLC	100.00%	\$	\$	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10 Nursing Salary	236	Extended Care Clinical, LLC	100.00%	236		17
18	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%			18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	29	29	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22 Employee Benefits	29	Extended Care Clinical, LLC	100.00%		(29)	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		\$ 265			\$ 265	\$ *	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>	<u>100.00%</u>	\$		15
16	V	<u>3 Housekeeping</u>	<u>52,861</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>49,338</u>	<u>(3,523)</u>	16
17	V	<u>4 Laundry</u>	<u>7,799</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>7,279</u>	<u>(520)</u>	17
18	V	<u>6 Repairs & Maintenance</u>	<u>37</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>34</u>	<u>(2)</u>	18
19	V	<u>10 Nursing</u>	<u>35,298</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>32,946</u>	<u>(2,352)</u>	19
20	V	<u>11 Activities</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			20
21	V	<u>12 Social Service</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			21
22	V	<u>20 Dues, Fees And Subscriptions</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			22
23	V	<u>21 Office And Clerical</u>	<u>163</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>152</u>	<u>(11)</u>	23
24	V	<u>22 Employee Benefits</u>	<u>1,076</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>1,004</u>	<u>(72)</u>	24
25	V	<u>24 Seminars & Education</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			25
26	V	<u>39 Ancillary</u>	<u>924</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>863</u>	<u>(62)</u>	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		\$ 98,158			\$ 91,617	\$ * (6,541)	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%	\$ 166,739	\$ 166,739	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	166,739	CCS Employee Benefits Group	100.00%		(166,739)	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		\$ 166,739			\$ 166,739	\$ *	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	35 Matrix Leasing	\$ 19,926	Vent Lease LLC	100.00%	\$ 9,217	\$ (10,709)
16	V	39 Ventilator Equipment	960	Vent Lease LLC	100.00%	444	(516)
17	V	39 Other Ancillary		Vent Lease LLC	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
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		\$ 20,886			\$ 9,661	\$ * (11,225)

* 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:

01/01/10

Ending:

12/31/10

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	1.78	3.83%	Mgmt. Fees	\$ 31,300	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.62	4.76%	Alloc. Salary	7,609	17-7	2
3	Adam Vales	Shareholder	Clerical	1.85%	See Attached	0.88	2.20%	Alloc. Salary	1,531	22-7	3
4	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.17	0.76%	Alloc. Salary	584	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										11
12	the IL Dept of HFS										12
13								TOTAL	\$ 41,024		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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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	34	\$ 3,931	\$	71,975	\$ 187	1
2	02	Food	Patient Days	34	10,940		71,975	521	2
3	03	Housekeeping	Patient Days	34	14,059		71,975	669	3
4	05	Utilities	Patient Days	34	31,923		71,975	1,519	4
5	06	Maintenance	Patient Days	34	91,744		71,975	4,366	5
6	17	Administrative	Patient Days	34	65,000		71,975	3,094	6
7	19	Professional Fees	Patient Days	34	271,007		71,975	12,898	7
8	20	Dues and Subscriptions	Patient Days	34	82,419		71,975	3,923	8
9	21	Office and Clerical	Patient Days	34	385,083		71,975	18,328	9
10	24	Seminar and Travel	Patient Days	34	4,022		71,975	191	10
11	25	Other Staff Admin. Trans.	Patient Days	34	19,982		71,975	951	11
12	26	Insurance	Patient Days	34	21,934		71,975	1,044	12
13	30	Depreciation	Patient Days	34	118,510		71,975	5,640	13
14	32	Interest	Patient Days	34	226,162		71,975	10,764	14
15	33	Real Estate Taxes	Patient Days	34	45,910		71,975	2,185	15
16	34	Rent - Building	Patient Days	34	31,555		71,975	1,502	16
17	35	Rent - Equipment & Auto	Patient Days	34	56,569		71,975	2,692	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,480,749	\$		\$ 70,474	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	71,975	9,366	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		71,975	1,565	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607				4
5	12	Admission (Direct)	Direct		34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	71,975	12,015	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	71,975	145,631	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		22,346	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		71,975	26,343	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			5,909	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					\$ 5,054,827	\$ 4,364,695		\$ 223,175	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,512,273	34	\$ 1,549	\$ 71,975	\$ 74	1
2	05	Utilities	Patient Days	1,512,273	34	3,268	71,975	156	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240	71,975	154	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624	71,975	8,644	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624	71,975	220	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370	71,975	2,064	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025	71,975	1,762	7
8	26	Insurance	Patient Days	1,512,273	34	4,213	71,975	201	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389	71,975	1,066	9
10	32	Interest	Patient Days	1,512,273	34	427,165	71,975	20,330	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058	71,975	241	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	71,975	5,531	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288	71,975	775	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	71,975	35,594	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	71,975	5,147	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	71,975	3,683	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816	71,975	6,226	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	71,975	50,942	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	71,975	7,292	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480	71,975	8,161	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,325,274	\$ 2,273,164	\$ 158,263	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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	01	Dietary Salary	Direct Allocation		\$ 15,960	\$ 15,960		\$	1
2	07	Emp. Ben. - General	Direct Allocation		1,662				2
3	10	Nursing Salary	Direct Allocation		495,330	495,330		236	3
4	12	Social Service Salary	Direct Allocation		274,597	274,597			4
5	15	Emp. Ben. - Healthcare	Direct Allocation		94,697			29	5
6	17	Administration Salary	Direct Allocation		82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation		10,053				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				\$ 974,688	\$ 868,276		\$ 265	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					49,338	2
3	4	Laundry	Direct Allocation					7,279	3
4	6	Repairs & Maintenance	Direct Allocation					34	4
5	10	Nursing	Direct Allocation					32,946	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					152	9
10	22	Employee Benefits	Direct Allocation					1,004	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					863	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				\$	\$		\$	91,617

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/10

Ending: 12/31/10

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		\$	\$		\$ 166,739	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				\$	\$		\$ 166,739	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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	35	Matrix Leasing	Direct Allocation		\$	\$		\$ 9,217	1
2	39	Ventilator Equipment	Direct Allocation					444	2
3	39	Other Ancillary	Direct Allocation						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				\$	\$		\$ 9,661	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/10 Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending:

12/31/10

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	1/26/99	\$ 9,518,795	\$ 8,734,676		\$ 495,116	1									
2	Dowd, Bloch & Bennett	X							157,584	2									
3	GMAC	X	Auto Loan	\$412.01			3,598	5.9000		3									
4										4									
5	See Supplemental Schedule									5									
Working Capital																			
6	Allocated from EC Consulting	X							10,764	6									
7	Allocated from EC Clinical	X							20,330	7									
8	See Supplemental Schedule									8									
9	TOTAL Facility Related			\$71,490.01		\$ 9,518,795	\$ 8,738,273		\$ 683,794	9									
B. Non-Facility Related*																			
10	Interest Income	X							(181,210)	10									
11	Interest Income - Bldg. Co	X							(534)	11									
12										12									
13	See Supplemental Schedule									13									
14	TOTAL Non-Facility Related					\$	\$		\$ (181,744)	14									
15	TOTALS (line 9+line14)					\$ 9,518,795	\$ 8,738,273		\$ 502,050	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 43,967 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:

01/01/10

Ending:

12/31/10

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																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	211,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	159,979	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(51,721)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	165,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	25,312	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	138,991	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	201,112	8
	2006	199,970	9
	2007	199,245	10
	2008	201,657	11
	2009	157,553	12

2010 Accrual = \$157,553 x 1.05 = \$165,400			
Allocated from Extended Care Consulting - \$2,185			
Allocated from Extended Care Clinical - \$241			

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/10

Ending:

12/31/10

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 2201 Main</u>			<u>15,734</u>	<u>2</u>
3	TOTALS			\$ 815,734	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/10

Ending:

12/31/10

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1999	83,114		20	3,790	3,790	42,698
10	Various		2000	251,874		20	12,528	12,528	135,750
11	Various		2001	59,759		20	2,988	2,988	28,809
12	Various		2002	147,991		20	13,094	13,094	118,857
13	Various		2003	29,651		20	1,483	1,483	11,436
14	Various		2004	70,279		20	6,799	6,799	47,069
15	Various		2005	42,283		20	4,228	4,228	22,544
16	Various		2006	25,997		20	2,600	2,600	11,636
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		6,285,648	200,516		194,755	(5,761)	2,205,178	67
68		70,397	4,791		4,791		33,554	68
69			56,145			(56,145)		69
70		\$ 7,066,993	\$ 261,452		\$ 247,056	\$ (14,396)	\$ 2,657,532	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		\$ 7,066,993	\$ 261,452		\$ 247,056	\$ (14,396)	\$ 2,657,532	1
2	Electrical Work	2008	3,000		20	300	300	650	2
3	Repaired Riser & Sewer	2008	10,572		20	1,057	1,057	2,203	3
4	Glass Doors	2009	2,850		20	285	285	356	4
5	New Water Line	2009	14,934		20	1,493	1,493	1,991	5
6	New Masterkey System	2009	6,924		20	692	692	808	6
7	Carpeting	2010	2,584		20	215	215	215	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)		\$ 7,107,857	\$ 261,452		\$ 251,100	\$ (10,352)	\$ 2,663,755	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	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		\$ 7,107,857	\$ 261,452		\$ 251,100	\$ (10,352)	\$ 2,663,755	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)	\$ 7,107,857	\$ 261,452		\$ 251,100	\$ (10,352)	\$ 2,663,755	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:

01/01/10

Ending:

12/31/10

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		\$ 7,107,857	\$ 261,452		\$ 251,100	\$ (10,352)	\$ 2,663,755	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)	\$ 7,107,857	\$ 261,452		\$ 251,100	\$ (10,352)	\$ 2,663,755	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	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		\$ 7,107,857	\$ 261,452		\$ 251,100	\$ (10,352)	\$ 2,663,755	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)	\$ 7,107,857	\$ 261,452		\$ 251,100	\$ (10,352)	\$ 2,663,755	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:

01/01/10

Ending:

12/31/10

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	1,898,771	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	193,164	9
10	Grasmere Real Estate (see attached)	2003	109,953		20	5,498	5,498	43,140	10
11	Grasmere Real Estate (see attached)	2004	24,653		20	1,233	1,233	8,267	11
12	Grasmere Real Estate (see attached)	2005	103,707		20	5,185	5,185	31,016	12
13	Exhaust Fan	2006	7,075		20	354	354	1,770	13
14	Vacuum Pump	2006	1,393		20	70	70	349	14
15	Window	2006	563		20	28	28	140	15
16	Gate	2006	5,700		20	285	285	1,425	16
17	Water Heater	2006	7,500		20	375	375	1,875	17
18	Elevator	2006	5,416		20	271	271	1,355	18
19	Boiler	2006	2,800		20	140	140	700	19
20	Plumbing	2006	45,784		20	2,289	2,289	10,353	20
21	Floor tiles	2006	1,045		20	52	52	261	21
22	Wall Paint	2006	532		20	27	27	134	22
23	Fire Alram	2006	1,100		20	55	55	275	23
24	Metal Hinges-Panels	2006	643		20	32	32	160	24
25	Cubicle Curtains	2007	3,559		20	178	178	712	25
26	Piping	2007	15,832		20	792	792	3,168	26
27	Fire Doors	2007	2,978		20	149	149	596	27
28	Piping Repair	2008	7,309		20	365	365	1,095	28
29	Elevator Repair	2008	2,738		20	137	137	411	29
30	Boiler Repair	2008	9,826		20	491	491	1,473	30
31	Carpet	2009	11,000		20	550	550	1,100	31
32	Fire Escape Repairs	2009	9,160		20	458	458	916	32
33	Masonry Repairs	2009	2,810		20	141	141	282	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:

01/01/10

Ending:

12/31/10

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	962	2
3	Window Screen	2009	5,880		20	294	294	588	3
4	Boiler	2009	6,061		20	303	303	606	4
5	New Exterior Lights	2009	1,140		20	57	57	114	5
6									6
7	Grasmere Real Estate Book Depreciation			200,516			(200,516)		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 (12F & 12G lines 1 thru 33)		\$ 6,285,648	\$ 200,516		\$ 194,755	\$ (5,761)	\$ 2,205,178	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	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main	2002	21,682	556	39	556		4,610	3
4	Allocated from Extended Care Clinical 2201 Main	2002	2,389	61	39	61		508	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	219	11	20	11		44	9
10	Allocated from Extended Care Consulting	2009	131	7	20	7		13	10
11	Allocated from Extended Care Consulting	2010	1,284	64	20	64		64	11
12									12
13	Allocated from Extended Care Consulting 2201 Main	2002	17,911	1,637	20	1,637		11,474	13
14	Allocated from Extended Care Consulting 2201 Main	2003	21,108	1,929	20	1,929		13,522	14
15	Allocated from Extended Care Consulting 2201 Main	2005	1,049	111	20	111		490	15
16	Allocated from Extended Care Consulting 2201 Main	2009	189	9	20	9		19	16
17									17
18	Allocated from Extended Care Clinical 2201 Main	2002	1,973	180	20	180		1,264	18
19	Allocated from Extended Care Clinical 2201 Main	2003	2,325	213	20	213		1,490	19
20	Allocated from Extended Care Clinical 2201 Main	2005	116	12	20	12		54	20
21	Allocated from Extended Care Clinical 2201 Main	2009	21	1	20	1		2	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.

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)		\$ 70,397	\$ 4,791		\$ 4,791	\$ 33,554	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:

01/01/10

Ending:

12/31/10

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	\$ 110,075	\$ 1,073	\$ 8,968	\$ 7,895	10	\$ 96,872	71
72	Current Year Purchases	3,243	69	196	127	10	196	72
73	Fully Depreciated Assets	183,629				10	183,629	73
74								74
75	TOTALS	\$ 296,947	\$ 1,142	\$ 9,165	\$ 8,023		\$ 280,697	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	\$	\$ 2,877	\$ 2,877	5	\$ 12,142	76
77		Alloc. Extended Care Consult.	2010	15,304	239	239		5	14,109	77
78		Alloc. Extended Care Clinical	2010	2,660	532	532		5	1,241	78
79										79
80	TOTALS			\$ 35,499	\$ 771	\$ 3,648	\$ 2,877		\$ 27,492	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)	\$ 8,256,037	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 263,365	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 263,912	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 547	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,971,944	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				2,332			5
6								6
7	TOTAL				\$ 2,332			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 15,883 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	Facility		\$	\$ 60	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 60	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	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): <u>See Supplemental</u>										1,609				1,609	13
14	TOTAL			\$				\$		\$	1,609		\$	1,609		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: 01/01/10

Ending:

12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,000	\$ 93,272	1
2	Cash-Patient Deposits	64,028	64,028	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	441,411	442,037	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	214,745	214,745	6
7	Other Prepaid Expenses	1,021	26,448	7
8	Accounts Receivable (owners or related parties)	6,400	6,400	8
9	Other(specify): <u>See Attached Schedule</u>	112	632,173	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 728,717	\$ 1,479,103	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	749,531	1,584,735	15
16	Equipment, at Historical Cost	210,569	1,813,892	16
17	Accumulated Depreciation (book methods)	(794,110)	(4,501,961)	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>	22,890	825,846	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 188,880	\$ 6,100,512	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 917,597	\$ 7,579,615	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,130,327	\$ 1,130,327	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,847	24,847	28
29	Short-Term Notes Payable	3,598	3,598	29
30	Accrued Salaries Payable	164,998	164,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,343	3,343	31
32	Accrued Real Estate Taxes(Sch.IX-B)		165,400	32
33	Accrued Interest Payable		40,980	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	40,659	40,659	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,367,772	\$ 1,574,152	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,734,676	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)	\$	\$ 8,734,676	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,367,772	\$ 10,308,828	46
47	TOTAL EQUITY(page 18, line 24)	\$ (450,175)	\$ (2,729,213)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 917,597	\$ 7,579,615	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,481,963	1
2	Restatements (describe):		2
3	Prior Year Dividends Booked in Late Journal Entry	(555,180)	3
4	Rounding	7	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,926,790	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,376,965)	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)	\$ (2,376,965)	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)	\$ (450,175)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place# 0044271Report Period Beginning: 01/01/10Ending: 12/31/10

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	\$ 7,568,521	1
2	Discounts and Allowances for all Levels	(8,723)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,559,798	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	8,723	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)	\$ 8,723	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	181,210	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 181,210	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)	\$ 7,749,748	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,430,798	31
32	Health Care	2,479,393	32
33	General Administration	4,675,934	33
B. Capital Expense			
34	Ownership	1,272,019	34
C. Ancillary Expense			
35	Special Cost Centers	150,309	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)*	\$ 10,126,713	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,376,965)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,376,965)	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: 01/01/10

Ending:

12/31/10

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	1,989	2,235	\$ 88,351	\$ 39.53	1
2	Assistant Director of Nursing	1,775	2,058	65,684	31.92	2
3	Registered Nurses	3,072	3,438	103,077	29.98	3
4	Licensed Practical Nurses	16,915	18,542	427,567	23.06	4
5	CNAs & Orderlies	59,153	66,297	683,857	10.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,265	50,369	22.24	9
10	Activity Assistants	7,619	8,573	85,372	9.96	10
11	Social Service Workers	31,799	34,802	623,608	17.92	11
12	Dietician	1,558	1,831	27,143	14.82	12
13	Food Service Supervisor	2,202	2,410	34,751	14.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,537	4,118	52,022	12.63	15
16	Dishwashers	11,235	12,509	114,749	9.17	16
17	Maintenance Workers	9,586	10,887	153,559	14.10	17
18	Housekeepers	23,932	26,515	263,584	9.94	18
19	Laundry					19
20	Administrator	1,878	2,143	117,867	55.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,700	10,697	152,659	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	1,846	2,084	21,883	10.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	28,122	28,559	198,854	6.96	33
34	TOTAL (lines 1 - 33)	217,878	239,963	\$ 3,264,956 *	\$ 13.61	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	56	\$ 2,664	01-03	35
36	Medical Director	Monthly	10,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,968	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	22	3,520	12-03	45
46	Other(specify)				46
47	<u>Art Therapist</u>	334	16,700	11-03	47
48	<u>See Attached - Extended Care Allocation</u>		236		48
49	TOTAL (lines 35 - 48)	412	\$ 44,488		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	\$ 117,867	Workers' Compensation Insurance	\$ 68,548	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	27,166	Advertising: Employee Recruitment	1,536		
				FICA Taxes	243,059	Health Care Worker Background Check			
				Employee Health Insurance	174,127	(Indicate # of checks performed <u>239</u>)	3,177		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	16,480		
				City Payroll Tax	5,088	Licenses & Fees	4,230		
				Employee Physicals	1,426	Allocated from EC Consulting	3,923		
				Pension Expense	25,725	Allocated from EC Clinical	220		
				Other Employee Welfare	661				
				Holiday Expense	3,300	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 Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
\$ 117,867				\$ 549,101		\$ 30,561			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Eric Rothner			\$ 31,300				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		8,252
\$ 31,300				\$			Allocated from EC Consulting		191
							Allocated from EC Clinical		1,762
							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		\$ 10,205
\$ 346,762									

* 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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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:

01/01/10

Ending:

12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$15,844
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,004 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.