

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	<u>69,429</u>	<u>372</u>		<u>69,801</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>69,429</u>	<u>372</u>		<u>69,801</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.54%

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

None (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 02/01/1999

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

YES Date 02/01/1999 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	247,815	43,017		290,832		290,832	226	291,058		1
2	Food Purchase		357,860		357,860		357,860	993	358,853		2
3	Housekeeping	276,507	56,138		332,645		332,645	757	333,402		3
4	Laundry		16,469	66,170	82,639		82,639		82,639		4
5	Heat and Other Utilities			173,567	173,567		173,567	1,708	175,275		5
6	Maintenance	152,480		160,491	312,971		312,971	26,592	339,563		6
7	Other (specify):*							1,153	1,153		7
8	TOTAL General Services	676,802	473,484	400,228	1,550,514		1,550,514	31,429	1,581,943		8
	B. Health Care and Programs										
9	Medical Director			7,100	7,100		7,100		7,100		9
10	Nursing and Medical Records	1,409,490	75,317	19,208	1,504,015		1,504,015	(120)	1,503,895		10
10a	Therapy										10a
11	Activities	303,739	36,700	15,275	355,714		355,714		355,714		11
12	Social Services	789,816	15,215	5,220	810,251		810,251		810,251		12
13	CNA Training										13
14	Program Transportation			1,358	1,358		1,358		1,358		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,503,045	127,232	48,161	2,678,438		2,678,438	(120)	2,678,318		16
	C. General Administration										
17	Administrative	120,413			120,413		120,413	30,015	150,428		17
18	Directors Fees										18
19	Professional Services			413,409	413,409		413,409	(307,302)	106,107		19
20	Dues, Fees, Subscriptions & Promotions			69,340	69,340		69,340	(35,183)	34,157		20
21	Clerical & General Office Expenses	180,471	16,544	122,449	319,464		319,464	114,578	434,042		21
22	Employee Benefits & Payroll Taxes			615,156	615,156		615,156	(6,426)	608,730		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,325	2,325		2,325	390	2,715		24
25	Other Admin. Staff Transportation			1,858	1,858		1,858	1,913	3,771		25
26	Insurance-Prop.Liab.Malpractice			255,260	255,260		255,260	20,282	275,542		26
27	Other (specify):*							35,842	35,842		27
28	TOTAL General Administration	300,884	16,544	1,479,797	1,797,225		1,797,225	(145,891)	1,651,334		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,480,731	617,260	1,928,186	6,026,177		6,026,177	(114,583)	5,911,594		29

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

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

Facility Name & ID Number

Grasmere Place

#0044271

Report Period Beginning:

01/01/14

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			46,979	46,979		46,979	242,175	289,154			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			240	240		240	352,097	352,337			32
33	Real Estate Taxes							210,260	210,260			33
34	Rent-Facility & Grounds			1,035,221	1,035,221		1,035,221	(1,032,000)	3,221			34
35	Rent-Equipment & Vehicles			4,343	4,343		4,343	1,125	5,468			35
36	Other (specify):*							41,943	41,943			36
37	TOTAL Ownership			1,086,783	1,086,783		1,086,783	(184,400)	902,383			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			960	960		960	(93)	867			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			960	960		960	(93)	867			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,480,731	617,260	3,015,929	7,113,920		7,113,920	(299,075)	6,814,845			45

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

Facility Name & ID Number Grasmere Place

0044271

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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	18,989	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(19)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(24,954)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,639)	21		24
25	Fund Raising, Advertising and Promotional	(1,009)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,365)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,997)		\$	30

BHF USE ONLY					
48		49		50	51
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(219,079)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (219,079)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (299,075)		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

Grasmere Place

Report Period Beginning: ID# 0044271
 Ending: 01/01/14
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty	\$ (120)	10	1
2	Theft Loss	199	21	2
3	Collection Expense	(2,652)	21	3
4	Building Company - Management Fee	(2,513)	21	4
5	Building Company - Audit Fee	(7,900)	19	5
6	Building Company - Filing Fees	(250)	20	6
7	Building Company - Amortization Expense	(2,990)	31	7
8	Alliance for Living - Political Dues	(11,459)	20	8
9	Annual Report	(250)	20	9
10	Non-allowable Legal	(3,732)	19	10
11	Non-allowable Professional Fees	(58)	19	11
12	Non-allowable Real Estate	(36)	33	12
13	Additional R&M	7,396	06	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		(24,365)	49

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grasmere Place# 0044271

Report Period Beginning:

01/01/14

Ending:

12/31/14

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			226									226	1
2	Food Purchase	(19)		1,012									993	2
3	Housekeeping			757									757	3
4	Laundry													4
5	Heat and Other Utilities			1,708									1,708	5
6	Maintenance	7,396		7,049	12,147								26,592	6
7	Other (specify):*				1,153								1,153	7
8	TOTAL General Services	7,377		10,752	13,300								31,429	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(120)											(120)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(120)											(120)	16
	C. General Administration													
17	Administrative			4,685	25,330								30,015	17
18	Directors Fees													18
19	Professional Services	(11,690)	7,900	(303,512)									(307,302)	19
20	Fees, Subscriptions & Promotions	(37,922)	250	2,489									(35,183)	20
21	Clerical & General Office Expenses	(53,605)	2,513	17,043	148,626								114,578	21
22	Employee Benefits & Payroll Taxes				(6,426)								(6,426)	22
23	Inservice Training & Education													23
24	Travel and Seminar			390									390	24
25	Other Admin. Staff Transportation			1,913									1,913	25
26	Insurance-Prop.Liab.Malpractice		18,225	2,057									20,282	26
27	Other (specify):*				35,842								35,842	27
28	TOTAL General Administration	(103,216)	28,888	(274,935)	203,372								(145,891)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,960)	28,888	(264,183)	216,672								(114,583)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grasmere Place# 0044271

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	18,989	216,848	6,338									242,175	30
31	Amortization of Pre-Op. & Org.	(2,990)	2,990											31
32	Interest		350,646	1,451									352,097	32
33	Real Estate Taxes	(36)	206,602	3,694									210,260	33
34	Rent-Facility & Grounds		(1,032,000)										(1,032,000)	34
35	Rent-Equipment & Vehicles			1,125									1,125	35
36	Other (specify):*		41,943										41,943	36
37	TOTAL Ownership	15,963	(212,971)	12,608									(184,400)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(93)							(93)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers					(93)							(93)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(79,997)	(184,083)	(251,575)	216,672	(93)							(299,075)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,032,000	Grasmere Real Estate, LLC	100.00%	\$	\$ (1,032,000)	1
2	V	32 Interest Income	430	Grasmere Real Estate, LLC	100.00%		(430)	2
3	V	21 Management Fee		Grasmere Real Estate, LLC	100.00%	2,513	2,513	3
4	V	19 Audit Fee		Grasmere Real Estate, LLC	100.00%	7,900	7,900	4
5	V	20 Filing Fees		Grasmere Real Estate, LLC	100.00%	250	250	5
6	V	30 Depreciation Expense		Grasmere Real Estate, LLC	100.00%	216,848	216,848	6
7	V	31 Amortization Expense		Grasmere Real Estate, LLC	100.00%	2,990	2,990	7
8	V	33 Real Estate Tax Expense		Grasmere Real Estate, LLC	100.00%	206,602	206,602	8
9	V	26 Insurance		Grasmere Real Estate, LLC	100.00%	18,225	18,225	9
10	V	32 Interest Expense - HUD		Grasmere Real Estate, LLC	100.00%	351,076	351,076	10
11	V	36 Mortgage Insurance		Grasmere Real Estate, LLC	100.00%	41,943	41,943	11
12	V							12
13	V							13
14	Total		\$ 1,032,430			\$ 848,347	\$ * (184,083)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 226	\$	226	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	1,012		1,012	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	757		757	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,708		1,708	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	7,049		7,049	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	4,685		4,685	20
21	V	19 Professional Fees	316,872	Extended Care Consulting, LLC	100.00%	13,360		(303,512)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,489		2,489	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	17,043		17,043	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	390		390	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,913		1,913	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	2,057		2,057	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	6,338		6,338	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	1,451		1,451	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,694		3,694	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,125		1,125	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		\$ 316,872			\$ 65,297	\$ *	(251,575)	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%	12,147	\$ 12,147
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%		
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,153	1,153
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%		
19	V						
20	V						
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	25,330	25,330
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	148,626	148,626
23	V	21 Office and Clerical (Direct)	21,420	Extended Care Consulting, LLC	100.00%	21,420	
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	32,041	32,041
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,801	3,801
26	V	22 Employee Benefits	6,426	Extended Care Consulting, LLC	100.00%		(6,426)
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		\$ 27,846			\$ 244,518	\$ * 216,672

* 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	39 Various Equipment	1,040	Vent Lease LLC	100.00%	947	\$ (93)
16	V						
17	V						
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		\$ 1,040			\$ 947	\$ * (93)

* 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%	\$ 167,085	\$ 167,085	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	167,085	CCS Employee Benefits Group	100.00%		(167,085)	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		\$ 167,085			\$ 167,085	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	WILLIAM ROTHNER ACCUM. TRUST	4.86%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		GRASMERE REAL ESTATE, LLC		BUILDING CO.	1
2	DANIEL ROTHNER ACCUM TRUST	4.86%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKEEP	2
3	RACHEL ROTHNER ACCUM TRUST	4.86%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	MELISSA ROTHNER ACCUM TRUST	4.86%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING LLC	EVANSTON	BUILDING CO.	4
5	ADAM VALES ACCUM TRUST	4.86%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	KATHRYN VALES ACCUM TRUST	4.86%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7	KIMBERLY VALES ACCUM TRUST	4.86%	MAJOR HOSPITAL DYER	DYER, IN				7
8	NEAL & BEATA ROTHNER	.69%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				8
9	DR. DAVID & SARA ROTHNER	.69%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10	LINDA VARDI	.69%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11	SANDRA & HILLEL KLIERS	.69%	MAJOR HOSPITAL SEBOS	HOBART, IN				11
12	NATHAN & SHIRLEY GRANDCHILDREN	3.24%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13	WILLIAM ROTHNER	1.85%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14	DANIEL ROTHNER	1.85%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15	RACHEL ROTHNER	1.85%	PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16	MELISSA ROTHNER	1.85%	RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17	ADAM VALES	1.85%	SHEFFIELD MANOR	DYER, IN				17
18	KATHRYN SILVERS	1.85%	SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19	KIMBERLY RUDOLPH	1.85%	SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20	N. & S. ROTHNER FAMILY TRUST	4.69%	ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Mark Steinberg	Relative	Administrative		See Attached	4.11	7.47%	Mgmt/Salary	\$ 14,937	17-7	1
2	Adam Vales	Shareholder	Clerical	1.85%	See Attached	1.44	3.60%	Alloc. Salary	2,660	22-7	2
3											3
4											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 the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 17,597		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 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

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	Patient Days	1,251,572	31	\$ 4,057	\$ 69,801	\$ 226	1
2	02	Food	Patient Days	1,251,572	31	18,150	69,801	1,012	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578	69,801	757	3
4	05	Utilities	Patient Days	1,251,572	31	30,626	69,801	1,708	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400	69,801	7,049	5
6	17	Administrative	Patient Days	1,251,572	31	84,000	69,801	4,685	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560	69,801	13,360	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626	69,801	2,489	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586	69,801	17,043	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989	69,801	390	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307	69,801	1,913	11
12	26	Insurance	Patient Days	1,251,572	31	36,877	69,801	2,057	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642	69,801	6,338	13
14	32	Interest	Patient Days	1,251,572	31	26,010	69,801	1,451	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240	69,801	3,694	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168	69,801	1,125	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,170,816	\$	\$ 65,297	25

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	69,801	12,147	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		69,801	1,153	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	69,801	25,330	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	69,801	148,626	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		21,420	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		69,801	32,041	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			3,801	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,662,721	\$ 3,975,053		\$ 244,518	25

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

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	<u>39</u>	<u>Various Equipment</u>	<u>Direct Allocation</u>					<u>947</u>	<u>1</u>
2									<u>2</u>
3									<u>3</u>
4									<u>4</u>
5									<u>5</u>
6									<u>6</u>
7									<u>7</u>
8									<u>8</u>
9									<u>9</u>
10									<u>10</u>
11									<u>11</u>
12									<u>12</u>
13									<u>13</u>
14									<u>14</u>
15									<u>15</u>
16									<u>16</u>
17									<u>17</u>
18									<u>18</u>
19									<u>19</u>
20									<u>20</u>
21									<u>21</u>
22									<u>22</u>
23									<u>23</u>
24									<u>24</u>
25	TOTALS				\$	\$		\$ <u>947</u>	<u>25</u>

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 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

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		\$	\$		\$ 167,085	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				\$	\$		\$ 167,085	25

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO										Original	Balance			
		A. Directly Facility Related																
		Long-Term																
1		HUD		X	Mortgage	\$71,078.00	01/26/99	\$ 9,518,795	\$ 8,169,475			\$ 351,076	1					
2													2					
3													3					
4													4					
5													5					
		Working Capital																
6		DIAWA		X	Line of Credit				150,000			240	6					
7		Dell		X					2,014				7					
8		See Supplemental Schedule										1,451	8					
9		TOTAL Facility Related				\$71,078.00		\$ 9,518,795	\$ 8,321,489			\$ 352,767	9					
		B. Non-Facility Related*																
10		Interest Income - Bldg. Co.		X								(430)	10					
11													11					
12													12					
13													13					
14		TOTAL Non-Facility Related						\$	\$			(430)	14					
15		TOTALS (line 9+line14)						\$ 9,518,795	\$ 8,321,489			\$ 352,337	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,943 Line # 36

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

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

Facility Name & ID Number

Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Alloc - Ext. Care Consulting		X				\$	\$			\$ 1,451					
9																
10																
11																
12																
13																
14	TOTAL Working Capital										1,451					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
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 2013 report.		\$	212,000		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.)		\$	207,860		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	(4,140)		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	214,400		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.)		\$			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.		\$	210,260		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>157,553</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>176,675</u>	9																
	2011	<u>175,849</u>	10																
	2012	<u>201,873</u>	11																
	2013	<u>204,166</u>	12																
2014 Accrual = \$204,166 x 1.05 = 214,400 (Rounded)																			
Allocated - Extended Care Consulting = \$3,694																			

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0044271
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-214-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>182,473.40</u>	\$ <u>182,473.40</u>
2. <u>14-17-214-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>10,851.54</u>	\$ <u>10,851.54</u>
3. <u>14-17-214-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>10,841.36</u>	\$ <u>10,841.36</u>
4. <u>See Attached</u>	<u>Allocation from 2201 W. Main</u>	\$ <u>162,082.08</u>	\$ <u>3,518.37</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>366,248.38</u></u>	\$ <u><u>207,684.67</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Grasmere Place

0044271 Report Period Beginning:

01/01/14 Ending:

12/31/14

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>Alloc - Care Centers Building</u>			<u>17,800</u>	<u>2</u>
3	TOTALS			\$ 817,800	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	216	1999	1964	\$ 5,578,000	\$ 216,848	35	\$ 159,371	\$ (57,477)	\$ 2,536,255	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various	1999		83,114		20	3,790	3,790	57,859	9
10	Various	2000		251,874		20	12,463	12,463	185,602	10
11	Various	2001		59,759		20	2,988	2,988	40,761	11
12	Various	2002		147,991		20	1,621	1,621	141,996	12
13	Various	2003		29,651		20	1,483	1,483	17,366	13
14	Various	2004		70,279		20	1,152	1,152	68,619	14
15	Various	2005		42,283		20	4,228	4,228	39,458	15
16	Various	2006		25,997		20	2,600	2,600	22,035	16
17	Various	2008		13,572		20	1,357	1,357	8,281	17
18	Various	2009		24,708		20	2,471	2,471	13,038	18
19	Various	2010		2,584		20	369	369	1,692	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		977,528			48,921	48,921	482,325	67
68		78,598			4,955	4,955	53,950	68
69					46,979	(46,979)		69
70		\$ 7,385,938	\$ 268,782		\$ 247,769	\$ (21,014)	\$ 3,669,239	70

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,385,938	\$ 268,782		\$ 247,769	\$ (21,014)	\$ 3,669,239	1
2	Boiler Repairs	2011	6,882		20	688	688	2,753	2
3	Smoking Room Ventilation	2011	3,000		20	600	600	2,400	3
4	Carpeting	2011	9,470		20	1,353	1,353	5,298	4
5	Elevator Door Lock Work	2011	9,479		20	948	948	3,239	5
6	Masonry Work	2011	25,880		20	1,294	1,294	4,960	6
7	Alley & Sidewalk Canopy	2011	6,950		20	348	348	1,303	7
8	Replace Tub, Vent, Shower Valve, Pipes, Repair Walls, Install Tile	2011	3,740		20	187	187	655	8
9	Roof Repairs	2011	4,000		20	200	200	650	9
10	Replace Groken Jockey Pump	2011	2,771		20	139	139	473	10
11	Formica Cubicles-North & South Halls-1St, 2Nd, 3Rd Floors	2012	18,900		20	1,890	1,890	5,670	11
12	Doors:Kitchen-Patio;Kitchen-Dining Rm; Masonry Repairs-Garba	2012	7,865		20	787	787	1,966	12
13	Curtains - Various Patient Rooms	2012	3,421		20	684	684	1,767	13
14	Dining Rm, Day Rm, Activity Rm, Lobby, Corridors - Vinyl Floori	2012	79,418		20	15,884	15,884	38,385	14
15	Concrete - Outdoor	2012	6,100		20	407	407	915	15
16	Dining Room Flooring	2012	9,013		20	901	901	1,953	16
17	Replaced 3 Vent Pipes On Water Heater	2012	4,483		20	224	224	672	17
18	Sewer Repairs	2012	3,392		20	170	170	424	18
19	Boiler Repairs	2012	4,890		20	489	489	1,060	19
20	Elevator - Replace Gate Switch And Sos Switch	2012	3,632		20	182	182	439	20
21	Install Security Cameras Inside & Outside Of Facility	2013	6,815		20	1,363	1,363	2,726	21
22	Install Concrete Patio	2013	4,660		20	466	466	854	22
23	Install Outside Smoking Room - Ground Floor Patio	2013	20,745		20	2,075	2,075	3,803	23
24	Repair Collapsed Sewer Line	2013	7,280		20	364	364	667	24
25	New Compressor	2013	2,772		20	277	277	439	25
26	Installed 3 Calcana Infrared Radiant Heaters, Sensors, & Gas Line	2013	15,975		20	799	799	1,198	26
27	Installed Emergency Pull Cord Transmitter	2013	4,204		20	420	420	596	27
28	Installed New 2" Tubes & Head Gaskets On Front & Rear Head O	2013	14,390		20	720	720	959	28
29	Installed New Commercial Grade Electric Gate Operator	2014	7,490		20	83	83	83	29
30	Replaced Temp. Controller, Rebuild Mixing Valve On Hot Water	2014	5,106		20	255	255	255	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,688,659	\$ 268,782		\$ 281,963	\$ 13,181	\$ 3,755,803	34

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$ 7,688,659	\$ 268,782		\$ 281,963	\$ 13,181	\$ 3,755,803		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)	\$ 7,688,659	\$ 268,782		\$ 281,963	\$ 13,181	\$ 3,755,803		34

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 7,688,659	\$ 268,782		\$ 281,963	\$ 13,181	\$ 3,755,803	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)	\$ 7,688,659	\$ 268,782		\$ 281,963	\$ 13,181	\$ 3,755,803	34

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 7,688,659	\$ 268,782		\$ 281,963	\$ 13,181	\$ 3,755,803	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)	\$ 7,688,659	\$ 268,782		\$ 281,963	\$ 13,181	\$ 3,755,803	34

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									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	253,540	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	65,132	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	13,199	11
12	Grasmere Real Estate (various)	2005	98,203		20	4,910	4,910	51,206	12
13	Grasmere Real Estate (various)	2006	87,251		20	4,363	4,363	35,479	13
14	Grasmere Real Estate (various)	2007	14,669		20	733	733	5,864	14
15	Piping Repair	2008	7,309		20	365	365	2,555	15
16	Elevator Repair	2008	2,738		20	137	137	959	16
17	Boiler Repair	2008	9,826		20	491	491	3,437	17
18	Fire Escape Repairs	2009	9,160		20	458	458	2,748	18
19	Masonry Repairs	2009	2,810		20	141	141	846	19
20	USA Satellite & Cable	2009	4,810		20	281	281	2,486	20
21	Window Screen	2009	5,880		20	294	294	1,764	21
22	Boiler	2009	6,061		20	303	303	1,818	22
23	Masonry Repairs	2010	51,315		20	2,566	2,566	12,830	23
24	Replace Plumbing in rooms 204 & 208	2011	3,610		20	181	181	543	24
25	New Sprinkler Heads	2012	15,512		20	776	776	2,328	25
26	Replace Underground Steam Pipes	2012	13,950		20	698	698	2,094	26
27	Replace Kitchen Floor and Walls	2012	8,970		20	449	449	1,347	27
28	Remove and Replace Walls in Dishwasher Room	2012	3,420		20	171	171	513	28
29	Roofing Repairs	2012	3,596		20	180	180	540	29
30	Remove and Replace Chimney	2012	8,280		20	414	414	1,242	30
31	Replace Steel Doors, Flooring	2012	9,890		20	495	495	1,485	31
32	Replace Window Hardware	2012	9,532		20	477	477	1,431	32
33	New Window Screens	2012	2,610		20	131	131	393	33
34	TOTAL (lines 1 thru 33)		\$ 815,879	\$		\$ 40,839	\$ 40,839	\$ 465,779	34

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12F, Carried Forward		\$ 815,879	\$		\$ 40,839	\$ 40,839	\$ 465,779	1
2	Window Replacement Parts	2012	7,638		20	382	382	1,146	2
3	Install Mass Notification System & Wireless Nurse Call System	2013	67,027		20	3,351	3,351	6,702	3
4	South Side 2nd Floor and North Side 3rd Floor	2013	86,984		20	4,349	4,349	8,698	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)		\$ 977,528	\$		\$ 48,921	\$ 48,921	\$ 482,325	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Care Centers Building	2002	24,529	629	39	629		7,731	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated - Extended Care Consulting	2007	257	13	20	13		103	9
10	Allocated - Extended Care Consulting	2009	153	8	20	8		46	10
11	Allocated - Extended Care Consulting	2010	1,505	75	20	75		376	11
12	Allocated - Extended Care Consulting	2011	542	27	20	27		108	12
13	Allocated - Extended Care Consulting	2012	178	9	20	9		27	13
14	Allocated - Extended Care Consulting	2014	2,473	124	20	124		124	14
15									15
16	Allocated - Care Centers Building	2002	20,263	1,727	20	1,727		20,263	16
17	Allocated - Care Centers Building	2003	23,879	2,035	20	2,035		23,879	17
18	Allocated - Care Centers Building	2005	1,186	126	20	126		1,058	18
19	Allocated - Care Centers Building	2009	214	11	20	11		64	19
20	Allocated - Care Centers Building	2014	3,419	171	20	171		171	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)		\$ 78,598	\$ 4,955		\$ 4,955	\$	\$ 53,950	34

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 78,598	\$ 4,955		\$ 4,955	\$	\$ 53,950	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)	\$ 78,598	\$ 4,955		\$ 4,955	\$	\$ 53,950	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 59,834	\$ 687	\$ 4,403	\$ 3,716	10	\$ 47,648	71
72	Current Year Purchases	27,066	413	2,505	2,092	10	2,505	72
73	Fully Depreciated Assets	1,863,402				10	1,863,402	73
74								74
75	TOTALS	\$ 1,950,302	\$ 1,100	\$ 6,908	\$ 5,808		\$ 1,913,555	75

D. Vehicle Costs. (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	\$	\$	\$	5	\$ 17,535	76
77		Alloc - Ext. Care Consulting	2012	10,065	284	284		5	8,928	77
78										78
79										79
80	TOTALS			\$ 27,600	\$ 284	\$ 284	\$		\$ 26,463	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)	\$ 10,484,361	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 270,166	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 289,155	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,989	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,695,820	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.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	Off Site Storage Rental				3,221			5
6								6
7	TOTAL				\$ 3,221			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 5,468 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/14 Ending: 12/31/14
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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER 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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 prescrpts							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>					960			960	13	
14	TOTAL			\$		\$ 960	\$		\$ 960	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.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(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	\$ 72,568	\$ 193,966	1
2	Cash-Patient Deposits	20,602	20,602	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	553,331	553,331	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	249,930	265,723	6
7	Other Prepaid Expenses	5,191	5,191	7
8	Accounts Receivable (owners or related parties)	8,400	8,400	8
9	Other(specify):	5	565,202	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 910,027	\$ 1,612,415	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	900,535	1,838,878	15
16	Equipment, at Historical Cost	287,771	1,945,506	16
17	Accumulated Depreciation (book methods)	(994,869)	(5,536,155)	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):		811,248	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 193,437	\$ 5,437,477	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,103,464	\$ 7,049,892	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 826,769	\$ 832,075	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,722	21,722	28
29	Short-Term Notes Payable	152,014	357,891	29
30	Accrued Salaries Payable	245,216	245,216	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,203	7,203	31
32	Accrued Real Estate Taxes(Sch.IX-B)		214,400	32
33	Accrued Interest Payable		28,934	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,252,924	\$ 1,707,441	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,963,598	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,963,598	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,252,924	\$ 9,671,039	46
47	TOTAL EQUITY(page 18, line 24)	\$ (149,460)	\$ (2,621,147)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,103,464	\$ 7,049,892	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (325,791)	1
2	Restatements (describe):		2
3	Depreciation, Office Expense, Employee Welfare	415	3
4	Pharmacy Cost and Pharmacy Consultant	(332)	4
5	Prior Period Income	1,349	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (324,359)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	174,899	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)	\$ 174,899	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)	\$ (149,460)	24 *

* This must agree with page 17, line 47.

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		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 7,288,699	1	
2	Discounts and Allowances for all Levels	(24,891)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,263,808	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	24,891	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)	\$ 24,891	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***		25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>See Supplemental Schedule</u>	120	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 120	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,288,819	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,550,514	31	
32	Health Care	2,678,438	32	
33	General Administration	1,797,225	33	
B. Capital Expense				
34	Ownership	1,086,783	34	
C. Ancillary Expense				
35	Special Cost Centers	960	35	
36	Provider Participation Fee		36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,113,920	40	
41	Income before Income Taxes (line 30 minus line 40)**	174,899	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 174,899	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,214,238	44
45	Private Pay - Net Inpatient Revenue	49,570	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,263,808	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	1,804	2,017	\$ 91,449	\$ 45.34	1
2	Assistant Director of Nursing	1,512	1,624	49,512	30.49	2
3	Registered Nurses	3,881	4,130	134,286	32.51	3
4	Licensed Practical Nurses	16,146	17,719	449,056	25.34	4
5	CNAs & Orderlies	56,585	63,133	662,456	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,940	2,143	54,165	25.28	9
10	Activity Assistants	7,883	8,683	87,248	10.05	10
11	Social Service Workers	37,263	41,388	789,816	19.08	11
12	Dietician					12
13	Food Service Supervisor	2,280	2,569	44,388	17.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,885	5,612	68,178	12.15	15
16	Dishwashers	13,684	14,843	135,249	9.11	16
17	Maintenance Workers	9,097	10,247	152,480	14.88	17
18	Housekeepers	23,748	26,858	276,507	10.30	18
19	Laundry					19
20	Administrator	1,936	2,175	120,413	55.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,853	13,532	180,471	13.34	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	1,789	2,041	22,731	11.14	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	19,139	19,343	162,326	8.39	33
34	TOTAL (lines 1 - 33)	215,425	238,057	\$ 3,480,731 *	\$ 14.62	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	\$		35
36	Medical Director	Monthly 7,100	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 18,608	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	29 5,220	12-03	45
46	Other(specify)			46
47	<u>Art Therapist</u>	306 15,275	11-03	47
48	<u>Psychiatrist</u>	Monthly 600	10-03	48
49	TOTAL (lines 35 - 48)	335 \$ 46,803		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

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	\$ 120,413	Workers' Compensation Insurance	\$ 96,336	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	38,731	Advertising: Employee Recruitment	1,351	
				FICA Taxes	266,266	Health Care Worker Background Check	5,374	
				Employee Health Insurance	181,154	(Indicate # of checks performed <u>180</u>)		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Licenses and Permits</u>	1,345	
				<u>Employee Physicals</u>	420	<u>Dues and Subscriptions</u>	21,608	
				<u>Pension Expense</u>	20,546			
				<u>Other Employee Welfare</u>	3,611	<u>Alloc - Ext. Care Consulting</u>	2,489	
				<u>Holiday Expense</u>	1,666			
						Less: <u>Public Relations Expense</u>	()	
						<u>Non-allowable advertising</u>	()	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,413	TOTAL (agree to Schedule V, line 22, col.8)	\$ 608,731	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,157	
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	2,325
							<u>Alloc - Ext. Care Consulting</u>	390
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 2,715
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Frost, Ruttenberg & Rothblatt</u>	<u>Accounting</u>		\$ 47,850					
<u>Personnel Planners</u>	<u>Unemployment Consulting</u>		2,030					
<u>Ext. Care Consulting</u>	<u>Home Office Expense</u>		316,872					
<u>Navex Global</u>	<u>Ethics and Compliance</u>		237					
<u>Pinnacle Consulting</u>	<u>Customer Satisfaction</u>		635					
<u>Legat</u>	<u>Architectural Consulting</u>		360					
<u>iDEPO</u>	<u>Court Reporters</u>		483					
<u>Prospect Resources</u>	<u>Natural Gas Procurement</u>		1,300					
<u>Blymas</u>	<u>Tax Credit Services</u>		2,030					
<u>Hamlin & Burton</u>	<u>Liability Management</u>		294					
<u>Plante & Moran</u>	<u>Accounting</u>		703					
<u>See Supplemental Schedule</u>			40,616					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 413,410					

* Attach copy of IMRF notifications

**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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

