

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0044271

Facility Name: Grasmere Place

Address: 4621 N. Sheridan Rd Chicago 60640
Number City Zip Code

County: Cook

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

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

(Signed) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place

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

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	216	Intermediate (ICF)	216	79,056	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	79,056	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	70,743	158		70,901	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,743	158		70,901	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.68%

SEE ACCOUNTANTS' COMPILATION REPORT

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 2/1/99

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 2/1/99 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	229,475	49,670		279,145		279,145	369	279,514			1
2	Food Purchase		349,895		349,895		349,895	(96)	349,799			2
3	Housekeeping	277,354	52,304		329,658		329,658	705	330,363			3
4	Laundry		11,922	46,295	58,217		58,217		58,217			4
5	Heat and Other Utilities			136,917	136,917		136,917	1,021	137,938			5
6	Maintenance	155,539		170,224	325,763		325,763	3,353	329,116			6
7	Other (specify):*							1,735	1,735			7
8	TOTAL General Services	662,368	463,791	353,436	1,479,595		1,479,595	7,087	1,486,682			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,388,680	84,306	14,571	1,487,557		1,487,557	(58)	1,487,499			10
10a	Therapy											10a
11	Activities	353,997	37,424	13,926	405,347		405,347		405,347			11
12	Social Services	745,420	13,518	2,587	761,525		761,525	348	761,873			12
13	CNA Training											13
14	Program Transportation			1,156	1,156		1,156		1,156			14
15	Other (specify):*							64	64			15
16	TOTAL Health Care and Programs	2,488,097	135,248	41,840	2,665,185		2,665,185	354	2,665,539			16
	C. General Administration											
17	Administrative	113,520			113,520		113,520	24,810	138,330			17
18	Directors Fees											18
19	Professional Services			456,493	456,493	(11,578)	444,915	(342,768)	102,147			19
20	Dues, Fees, Subscriptions & Promotions			70,563	70,563		70,563	(44,725)	25,838			20
21	Clerical & General Office Expenses	168,678	22,080	143,195	333,953		333,953	98,798	432,751			21
22	Employee Benefits & Payroll Taxes			610,785	610,785		610,785	(6,016)	604,769			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,504	8,504		8,504	328	8,832			24
25	Other Admin. Staff Transportation			1,209	1,209		1,209	1,222	2,431			25
26	Insurance-Prop.Liab.Malpractice			251,238	251,238		251,238	2,743	253,981			26
27	Other (specify):*							34,185	34,185			27
28	TOTAL General Administration	282,198	22,080	1,541,987	1,846,265	(11,578)	1,834,687	(231,423)	1,603,264			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,432,663	621,119	1,937,263	5,991,045	(11,578)	5,979,467	(223,982)	5,755,485			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			50,571	50,571		50,571	226,385	276,956			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			614	614		614	392,058	392,672			32
33	Real Estate Taxes					11,578	11,578	178,186	189,764			33
34	Rent-Facility & Grounds			1,034,508	1,034,508		1,034,508	(1,032,000)	2,508			34
35	Rent-Equipment & Vehicles			4,405	4,405		4,405	1,147	5,552			35
36	Other (specify):*							42,602	42,602			36
37	TOTAL Ownership			1,090,098	1,090,098	11,578	1,101,676	(191,622)	910,054			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			23	23		23		23			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			23	23		23		23			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,432,663	621,119	3,027,384	7,081,166		7,081,166	(415,604)	6,665,562			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(794)	02		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	15,110	30		9
10	Interest and Other Investment Income	(93,439)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	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	(540)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(5,288)	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	(160,981)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (305,940)		\$	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 Amount	2 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)	(109,664)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (109,664)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (415,604)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Grasmere Place

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	COPE Dues	\$ (10,869)	20	1
2	Alliance for Living - Political Dues	(33,670)	20	2
3	Other Income	(647)	21	3
4	Jury Duty Income	(34)	10	4
5	Patient Clothing	(24)	10	5
6	Collection Expense	(2,346)	21	6
7	Capitalized R&M	(16,397)	6	7
8	Building Company - Audit Fee	(7,500)	19	8
9	Building Company - Trust Fee	(200)	20	9
10	Building Company - Filing Fee	(250)	20	10
11	Building Company - Amortization	(2,260)	36	11
12	Building Company - Misc. Admin. Expense	(175)	21	12
13	Annual Report	(250)	20	13
14	Non-Allowable Legal	(2,896)	19	14
15	Additional R&M	3,545	6	15
16	Capitalized R&M (building company)	(87,008)	6	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	(160,981)		49

Grasmere Place

Report Period Beginning:

Ending:

ID#

0044271

01/01/12

12/31/12

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	15,110	201,014	10,261									226,385	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(93,439)	479,116	6,381									392,058	32
33	Real Estate Taxes		174,949	3,237									178,186	33
34	Rent-Facility & Grounds		(1,032,000)										(1,032,000)	34
35	Rent-Equipment & Vehicles			1,578			(431)						1,147	35
36	Other (specify):*	(2,260)	44,862										42,602	36
37	TOTAL Ownership	(80,589)	(132,059)	21,457			(431)						(191,622)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(305,940)	(32,905)	(280,593)	203,917	348	(431)						(415,604)	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	Rent	\$ 1,032,000	Grasmere Real Estate, LLC	100.00%	\$	(1,032,000)	1
2	V	32	Interest	632	Grasmere Real Estate, LLC	100.00%	479,748	479,116	2
3	V	19	Audit Fees		Grasmere Real Estate, LLC	100.00%	7,500	7,500	3
4	V	20	Trust Fees		Grasmere Real Estate, LLC	100.00%	200	200	4
5	V	20	Filing Fees		Grasmere Real Estate, LLC	100.00%	250	250	5
6	V	30	Depreciation		Grasmere Real Estate, LLC	100.00%	201,014	201,014	6
7	V	36	Amortization		Grasmere Real Estate, LLC	100.00%	2,260	2,260	7
8	V	33	Real Estate Tax		Grasmere Real Estate, LLC	100.00%	174,949	174,949	8
9	V	26	Insurance		Grasmere Real Estate, LLC	100.00%	1,301	1,301	9
10	V	36	Mortgage Insurance		Grasmere Real Estate, LLC	100.00%	42,602	42,602	10
11	V	21	Misc. Admin. Expense		Grasmere Real Estate, LLC	100.00%	175	175	11
12	V	06	Repairs & Maintenance		Grasmere Real Estate, LLC	100.00%	89,728	89,728	12
13	V								13
14	Total			\$ 1,032,632			\$ 999,727	\$ * (32,905)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 369	\$ 369	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	706	706	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	705	705	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,021	1,021	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,041	4,041	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,366	4,366	20
21	V	19	Professional Fees	346,044	Extended Care Consulting, LLC	100.00%	6,172	(339,872)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	5,352	5,352	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	18,270	18,270	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	328	328	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,222	1,222	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,442	1,442	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	10,261	10,261	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,381	6,381	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,237	3,237	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,578	1,578	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 346,044			\$ 65,451	\$ * (280,593)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	9,444	\$	9,444
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%	1,735		1,735
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%	20,444		20,444
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	143,503		143,503
23	V	21	Office and Clerical (Direct)	20,025	Extended Care Consulting, LLC	100.00%	20,583		558
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	30,122		30,122
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,063		4,063
26	V	22	Employee Benefits	5,952	Extended Care Consulting, LLC	100.00%			(5,952)
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			\$ 25,977			\$ 229,894	\$ *	203,917

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	12	Social Service / Admission Salary	27	Extended Care Clinical, LLC	100.00%	375	\$	348
16	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	64		64
17	V	22	Employee Benefits	64	Extended Care Clinical, LLC	100.00%			(64)
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			\$ 91			\$ 439	\$ *	348

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Matrix Leasing	431	Vent Lease LLC	100.00%		\$ (431)	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			\$ 431			\$	\$ * (431)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 193,630	\$ 193,630	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	193,630	CCS Employee Benefits Group	100.00%		(193,630)	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			\$ 193,630			\$ 193,630	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	ADAM VALES	1.851%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	GRASMERE REAL ESTATE, LLC		BUILDING CO.	1
2	ADAM VALES ACCUM. TRUST	4.861%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKING	2
3	DANIEL ROTHNER	1.851%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC CHICAGO		EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	DANIEL ROTHNER ACCUM TRUST	4.861%	BRIAR PLACE LTD	INDIAN HEAD PARK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	DR. DAVID & SARA ROTHNER	0.694%	CHATEAU NURSING AND REHABILITATION CENTER, LLC	WILLOWBROOK	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	5
6	KATHRYN SILVERS	1.851%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	6
7	KATHRYN VALES ACCUM TRUST	4.861%	DEVON GABLES REHABILITATION CENTER	ARIZONA				7
8	KIMBERLY RICHMOND ACCUM. TRUST	4.861%	DYER NURSING & REHAB	DYER, IN				8
9	KIMBERLY RUDOLPH	1.851%	FOOTHILLS REHABILITATION CENTER LLC	ARIZONA				9
10	LINDA VARDI	0.694%	GOLDEN PLAINES REHABILITATION CENTER	KANSAS				10
11	MELISSA ROTHNER	1.851%	HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				11
12	MELISSA ROTHNER ACCUM. TRUST	4.861%	HOMESTEAD NURSING & REAHB	LINCOLN, NE				12
13	N. & S. ROTHNER FAMILY TRUST	46.990%	LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14	NATHAN & SHIRLEY GRANDCHILDREN	3.240%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				14
15	NEAL & BEATA ROTHNER	0.694%	LANCASTER MANOR	LINCOLN, NE				15
16	RACHEL ROTHNER	1.851%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17	RACHEL ROTHNER ACCUM TRUST	4.861%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18	SANDRA & HILLEL KLIERS	0.694%	OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19	WILLIAM ROTHNER	1.851%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20	WILLIAM ROTHNER ACCUM. TRUST	4.861%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOLBART, IN				23
24			SHEFFIELD MANOR	DYER, IN				24
25			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				29
30			WHEATON CARE CENTER	WHEATON				30

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

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	Adam Vales	Shareholder	Clerical	1.85	See Attached	1.66	4.15%	Alloc. Salary	\$ 3,037	22-7	1
2	Mark Steinberg	Relative	Administrative	0	See Attached	4.69	8.53%	Mgmt/Salary	16,312	17-7	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	\$ 19,349		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

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,364,178	31	\$ 7,101	\$	70,901	\$ 369	1
2	02	Food	Patient Days	1,364,178	31	13,586		70,901	706	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		70,901	705	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		70,901	1,021	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		70,901	4,041	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		70,901	4,366	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		70,901	6,172	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		70,901	5,352	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		70,901	18,270	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		70,901	328	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		70,901	1,222	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		70,901	1,442	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		70,901	10,261	13
14	32	Interest	Patient Days	1,364,178	31	122,765		70,901	6,381	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		70,901	3,237	15
16	34	Rent - Building	Patient Days	1,364,178	31			70,901		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		70,901	1,578	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,259,303	\$		\$ 65,451	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	06	Maintenance (Pooled)	Patient Days	1,364,178	31	181,713	181,713	70,901	9,444	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		70,901	1,735	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	70,901	20,444	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	70,901	143,503	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		20,583	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		70,901	30,122	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			4,063	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					\$ 4,679,511	\$ 3,961,379		\$ 229,894	25

Ending: 12/31/12

(847) 905-3030

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

(847)905-4040

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	HUD		X	Mortgage	\$71,078.00	1/26/99	\$ 9,518,795	\$ 8,454,632			\$ 479,748	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Diawa		X	Line of Credit							614	6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related				\$71,078.00		\$ 9,518,795	\$ 8,454,632			\$ 480,362	9	
	B. Non-Facility Related*												
10	Allocated from ECConsulting										6,381	10	
11	Interest Income										(93,439)	11	
12	Interest Income - Bldg Co.										(632)	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (87,690)	14	
15	TOTALS (line 9+line14)						\$ 9,518,795	\$ 8,454,632			\$ 392,672	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 42,602 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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 2011 report.	\$	185,500		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.)	\$	179,086		2
3. Under or (over) accrual (line 2 minus line 1).	\$	(6,414)		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	184,600		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.)	\$	11,578		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.	\$	189,764		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2007	199,245	8	
	2008	201,657	9	
	2009	157,553	10	
	2010	176,675	11	
	2011	175,849	12	
2012 Accrual = 175,849 x 1.05 = 184,600 (rounded)				
Allocated from Extended Care Consulting \$3,237				

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Grasmere Place</u>	COUNTY	<u>Cook</u>
---------------	-----------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-214-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>156,399.44</u>	\$ <u>156,399.44</u>
2. <u>14-17-214-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>9,730.57</u>	\$ <u>9,730.57</u>
3. <u>14-17-214-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>9,719.06</u>	\$ <u>9,719.06</u>
4. <u>See Attached</u>	<u>Allocation from 2201 Main</u>	\$ <u>127,119.67</u>	\$ <u>2,571.55</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>302,968.74</u>	\$ <u>178,420.62</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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	Facility		1999	\$ 800,000	1
2	Allocated from 2201 Main			16,588	2
3	TOTALS			\$ 816,588	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	35	\$ 159,371	\$ 159,371	\$ 2,217,513
5										
6										
7										
8										
	Improvement Type**									
9	Various		1999		83,114		20	3,790	3,790	50,279
10	Various		2000		251,874		20	12,463	12,463	160,676
11	Various		2001		59,759		20	2,988	2,988	34,785
12	Various		2002		147,991		20	6,456	6,456	138,406
13	Various		2003		29,651		20	1,483	1,483	14,401
14	Various		2004		70,279		20	6,799	6,799	60,668
15	Various		2005		42,283		20	4,228	4,228	31,001
16	Various		2006		25,997		20	2,600	2,600	16,835
17	Various		2008		13,572		20	1,357	1,357	5,567
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

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	Related Building Company (Pages 12F & 12G)	845,971	201,014		42,300	(158,714)	389,223	67
68	Related Party Allocations (Pages 12H & 12I)	67,756	4,596		4,596		41,064	68
69	Financial Statement Depreciation		50,571			(50,571)		69
70	TOTAL (lines 4 thru 69)	\$ 7,216,247	\$ 256,181		\$ 248,432	\$ (7,749)	\$ 3,160,419	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 12A, Carried Forward		\$ 7,216,247	\$ 256,181		\$ 248,432	\$ (7,749)	\$ 3,160,419	1
2	Glass Doors	2009	2,850		20	285	285	926	2
3	New Water Line	2009	14,934		20	1,493	1,493	4,978	3
4	New Masterkey System	2009	6,924		20	692	692	2,193	4
5	Carpeting	2010	2,584		20	369	369	954	5
6	Boiler Repairs	2011	6,882		20	688	688	1,376	6
7	Smoking Room Ventilation	2011	3,000		20	600	600	1,200	7
8	Carpeting	2011	9,470		20	1,353	1,353	2,593	8
9	Elevator Door Lock Work	2011	9,479		20	948	948	1,343	9
10	Masonry Work	2011	25,880		20	1,294	1,294	2,372	10
11	Alley & Sidewalk Canopy	2011	6,950		20	348	348	608	11
12	Replace Tub, Vent, Shower Valve, Pipes, Repair Walls, Install Tile	2011	3,740		20	187	187	281	12
13	Roof Repairs	2011	4,000		20	200	200	250	13
14	Replace Broken Jockey Pump	2011	2,771		20	139	139	196	14
15	Formica Cubicles-North And South Halls-1St, 2Nd, 3Rd Floors	2012	18,900		20	1,890	1,890	1,890	15
16	Doors:Kitchen-Patio;Kitchen-Dining Rm;Masonry Repairs-Garba	2012	7,865		20	393	393	393	16
17	Curtains - Various Patient Rooms	2012	3,421		20	399	399	399	17
18	Dining Rm, Day Rm, Activity Rm, Lobby, Corridors - Flooring	2012	79,418		20	3,309	3,309	3,309	18
19	Concrete	2012	6,100		20	102	102	102	19
20	Dining Room Flooring	2012	9,013		20	150	150	150	20
21	Replaced 3 Vent Pipes On Water Heater	2012	4,483		20	224	224	224	21
22	Sewer Repairs	2012	3,392		20	85	85	85	22
23	Boiler Repairs	2012	4,890		20	82	82	82	23
24	Elevator-Replace Gate Switch & Sos Switch	2012	3,632		20	76	76	76	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)		\$ 7,456,824	\$ 256,181		\$ 263,738	\$ 7,557	\$ 3,186,398	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Totals from Page 12B, Carried Forward		\$7,456,824	\$256,181		\$263,738	\$7,557	\$3,186,398	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
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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)		\$7,456,824	\$256,181		\$263,738	\$7,557	\$3,186,398	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Totals from Page 12C, Carried Forward		\$7,456,824	\$256,181		\$263,738	\$7,557	\$3,186,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,456,824	\$256,181		\$263,738	\$7,557	\$3,186,398	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Totals from Page 12D, Carried Forward		\$ 7,456,824	\$ 256,181		\$ 263,738	\$ 7,557	\$ 3,186,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,456,824	\$ 256,181		\$ 263,738	\$ 7,557	\$ 3,186,398	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Building Company Information								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	223,352	9
10	Grasmere Real Estate (various)	2003	109,953		20	5,498	5,498	54,136	10
11	Grasmere Real Estate (various)	2004	24,653		20	1,233	1,233	10,733	11
12	Grasmere Real Estate (various)	2005	103,707		20	5,185	5,185	41,386	12
13	Grasmere Real Estate (various)	2006	79,551		20	3,978	3,978	26,753	13
14	Cubicle Curtains	2007	3,559		20	178	178	1,068	14
15	Piping	2007	15,832		20	792	792	4,752	15
16	Fire Doors	2007	2,978		20	149	149	894	16
17	Piping Repair	2008	7,309		20	365	365	1,825	17
18	Elevator Repair	2008	2,738		20	137	137	685	18
19	Boiler Repair	2008	9,826		20	491	491	2,455	19
20	Carpet	2009	11,000		20	550	550	2,200	20
21	Fire Escape Repairs	2009	9,160		20	458	458	1,832	21
22	Masonry Repairs	2009	2,810		20	141	141	564	22
23	USA Satellite & Cable	2009	9,620		20	481	481	1,924	23
24	Window Screen	2009	5,880		20	294	294	1,176	24
25	Boiler	2009	6,061		20	303	303	1,212	25
26	New Exterior Lights	2009	1,140		20	57	57	228	26
27	Masonry Repairs	2010	51,315		20	2,566	2,566	7,698	27
28	Replace Window Hardware	2012	9,532		20	477	477	477	28
29	New Window Screens	2012	2,610		20	131	131	131	29
30	Window Replacement Parts	2012	7,638		20	382	382	382	30
31	New Sprinkler Heads	2012	15,512		20	776	776	776	31
32	Replace Plumbing in rooms 204 & 208	2012	3,610		20	181	181	181	32
33	Replace Underground Steam Pipes	2012	13,950		20	698	698	698	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Replace Kitchen Floor and Walls	2012	8,970		20	449	449	449	2
3	Remove and Replace Walls in Dishwasher Room	2012	3,420		20	171	171	171	3
4	Roofing Repairs	2012	3,596		20	180	180	180	4
5	Remove and Replace Chimney	2012	8,280		20	414	414	414	5
6	Replace Steel Doors, Flooring	2012	9,890		20	495	495	495	6
7	Grasmere Real Estate Book Depreciation			201,014			(201,014)		7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 845,971	\$ 201,014		\$ 42,300	\$ (158,714)	\$ 389,223	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated from Extended Care Consulting - 2201 Main</u>	2002	22,859	586	39	586		6,032	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated from Extended Care Consulting</u>	2007	239	12	20	12		72	9
10	<u>Allocated from Extended Care Consulting</u>	2009	143	7	20	7		29	10
11	<u>Allocated from Extended Care Consulting</u>	2010	1,402	70	20	70		210	11
12	<u>Allocated from Extended Care Consulting</u>	2011	505	25	20	25		51	12
13	<u>Allocated from Extended Care Consulting</u>	2012	166	8	20	8		8	13
14									14
15	<u>Allocated from Extended Care Consulting - 2201 Main</u>	2002	18,883	1,726	20	1,726		15,548	15
16	<u>Allocated from Extended Care Consulting - 2201 Main</u>	2003	22,253	2,034	20	2,034		18,323	16
17	<u>Allocated from Extended Care Consulting - 2201 Main</u>	2005	1,106	118	20	118		751	17
18	<u>Allocated from Extended Care Consulting - 2201 Main</u>	2009	200	10	20	10		40	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$67,756	\$4,596		\$4,596	\$	\$41,064	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$1,716,167	\$4,054	\$7,973	\$3,919	10	\$118,639	71
72	Current Year Purchases	6,929		1,117	1,117	10	1,117	72
73	Fully Depreciated Assets	238,091				10	238,091	73
74								74
75	TOTALS	\$1,961,187	\$4,054	\$9,090	\$5,036		\$357,847	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	\$	\$2,517	\$2,517	5	\$17,535	76
77		Allocated from ECConsulting	2012	8,055	1,611	1,611		5	8,055	77
78										78
79										79
80	TOTALS			\$25,590	\$1,611	\$4,128	\$2,517		\$25,590	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$10,260,189	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$261,846	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$276,956	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$15,110	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,569,835	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.

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.

		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				2,508			5
6								6
7	TOTAL				\$ 2,508			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 5,552
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

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

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	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): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 9,157	\$ 124,694	1
2	Cash-Patient Deposits	18,108	18,108	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	10,150	10,150	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	286,165	286,165	6
7	Other Prepaid Expenses	5,315	44,228	7
8	Accounts Receivable (owners or related parties)	8,400	8,400	8
9	Other(specify): See Attached Schedule	110,760	709,054	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 448,055	\$ 1,200,799	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	881,409	1,706,803	15
16	Equipment, at Historical Cost	244,977	1,848,300	16
17	Accumulated Depreciation (book methods)	(896,077)	(5,010,849)	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): See Attached Schedule		798,436	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 230,309	\$ 5,720,690	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 678,364	\$ 6,921,489	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 640,131	\$ 640,133	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,954	31,954	28
29	Short-Term Notes Payable		152,270	29
30	Accrued Salaries Payable	194,632	194,632	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,173	6,173	31
32	Accrued Real Estate Taxes(Sch.IX-B)		184,600	32
33	Accrued Interest Payable		39,666	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 872,890	\$ 1,249,428	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,302,362	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,302,362	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 872,890	\$ 9,551,790	46
47	TOTAL EQUITY(page 18, line 24)	\$ (194,526)	\$ (2,630,301)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 678,364	\$ 6,921,489	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 310,828	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 310,828	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	294,646	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	(800,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (505,354)	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)	\$ (194,526)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$7,251,090	1
2	Discounts and Allowances for all Levels	(27,209)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$7,223,881	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	794	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,209	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)	\$28,003	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	93,439	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$93,439	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	30,489	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$30,489	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$7,375,812	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,479,595	31
32	Health Care	2,665,185	32
33	General Administration	1,846,265	33
	B. Capital Expense		
34	Ownership	1,090,098	34
	C. Ancillary Expense		
35	Special Cost Centers	23	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)*	\$7,081,166	40
41	Income before Income Taxes (line 30 minus line 40)**	294,646	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$294,646	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$7,200,221	44
45	Private Pay - Net Inpatient Revenue	23,660	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)	\$7,223,881	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.

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	2,018	2,219	\$ 92,925	\$ 41.88	1
2	Assistant Director of Nursing	1,782	2,093	67,563	32.28	2
3	Registered Nurses	2,673	2,956	93,163	31.52	3
4	Licensed Practical Nurses	17,807	19,742	469,228	23.77	4
5	CNAs & Orderlies	54,952	61,947	643,367	10.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,870	2,173	49,778	22.91	9
10	Activity Assistants	8,746	9,749	99,514	10.21	10
11	Social Service Workers	36,900	40,923	745,420	18.22	11
12	Dietician					12
13	Food Service Supervisor	3,765	4,304	66,632	15.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,580	6,285	72,540	11.54	15
16	Dishwashers	9,010	9,851	90,303	9.17	16
17	Maintenance Workers	9,672	10,722	155,539	14.51	17
18	Housekeepers	24,907	27,522	277,354	10.08	18
19	Laundry					19
20	Administrator	1,922	2,117	113,520	53.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,034	11,284	168,678	14.95	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	1,904	2,127	22,434	10.55	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	28,014	28,371	204,705	7.22	33
34	TOTAL (lines 1 - 33)	221,556	244,385	\$ 3,432,663 *	\$ 14.05	34

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	9,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	14,571	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	16	2,560	12-03	45
46	Other(specify)				46
47	Art Therapist Consultant	278	13,925	11-03	47
48	See Attached		27	12-03	48
49	TOTAL (lines 35 - 48)	294	\$ 40,683		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberGrasmere Place# 0044271Report Period Beginning:01/01/12Ending:12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Celeste Jensen	Administrator	0	\$ 113,520
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 113,520

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting	\$ 23,838
Various	Legal	22,649
Paycor	Payroll Processing	19,145
Pro Payroll Solutions	Payroll Processing	7,829
National Datacare Corp.	Resident Fund Processing	4,215
Personnel Planners	Unemployment Consult.	2,711
Pharmacy Cost Management	Management	3,146
DJN	Customer Service Training	175
Pinnacle Consulting	Customer Satisfaction	569
Prospect Resources	Natural Gas Procurement	1,300
HFG	Line of Credit	21,097
See Supplemental Schedule		349,819
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 456,493

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 83,484	
Unemployment Compensation Insurance	50,876	
FICA Taxes	256,360	
Employee Health Insurance	183,020	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Chicago Employer Tax	680	
Pension	25,721	
Other Employee Welfare	1,853	
Holiday Expense	2,775	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 604,769

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$ 1,990	
Advertising: Employee Recruitment	780	
Health Care Worker Background Check (Indicate # of checks performed 99)	4,587	
Patient Background Checks		
Dues & Subscriptions	11,899	
License & Fees	1,230	
Advertising & Promotion	5,288	
Allocated from ECConsulting	5,352	
Less: Public Relations Expense	()	
Non-allowable advertising	(5,288)	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 25,838

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	8,504
Allocated from ECConsulting	328
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 8,832

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ICLTC \$20,736 / Alliance for Living \$19,944
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$184

Line

10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$794
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100% ln. 14

d.

Have vehicle usage logs been maintained?

No

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

No

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT