FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0046904

Facility Name: Granite Nursing & Rehab Ctr

Address: 3500 Century Dr (Number) Granite City (City) 62040 (Zip Code)

County: Madison

Telephone Number: (618) 877-2700 **Fax #** (618) 877-0711

HFS ID Number:

Date of Initial License for Current Owners: January 1, 2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary F. Eye **Telephone Number:** (716) 972-2392
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 1/1/12 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) _____ (Date)
(Type or Print Name) Gary F. Eye
(Title) Senior VP of Finance of Tara Cares

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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**

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	86	Skilled (SNF)	86	31,476	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,476	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,342	7,131	7,333	26,806	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,342	7,131	7,333	26,806	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.16%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
outpatient therapy

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date January 1, 2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 86 and days of care provided 4,545

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 1/1 to 12/31/12 Fiscal Year: 1/1 to 12/31/12

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

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	154,233	14,834	11,587	180,654		180,654		180,654			1
2	Food Purchase		169,023		169,023		169,023	(208)	168,815			2
3	Housekeeping	127,736	18,263		145,999		145,999		145,999			3
4	Laundry	16,198	6,672		22,870		22,870		22,870			4
5	Heat and Other Utilities			97,852	97,852		97,852	(2,120)	95,732			5
6	Maintenance	24,395	21,350	43,249	88,994		88,994	(10,435)	78,559			6
7	Other (specify):* see trial balance			32,578	32,578		32,578		32,578			7
8	TOTAL General Services	322,562	230,142	185,266	737,970		737,970	(12,763)	725,207			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,761,547	121,006	27,315	1,909,868		1,909,868	(9,636)	1,900,232			10
10a	Therapy		5,762	931,381	937,143		937,143	26,353	963,496			10a
11	Activities	27,677	677	2,462	30,816		30,816		30,816			11
12	Social Services	32,035		1,530	33,565		33,565		33,565			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* see trial balance			8,393	8,393		8,393	(2,068)	6,325			15
16	TOTAL Health Care and Programs	1,821,259	127,445	980,681	2,929,385		2,929,385	14,649	2,944,034			16
	C. General Administration											
17	Administrative	238,943		318,888	557,831		557,831	(127,802)	430,029			17
18	Directors Fees											18
19	Professional Services			77,781	77,781		77,781	(2,740)	75,041			19
20	Dues, Fees, Subscriptions & Promotions			24,673	24,673		24,673	(10,440)	14,233			20
21	Clerical & General Office Expenses		25,858	31,738	57,596		57,596	(3,914)	53,682			21
22	Employee Benefits & Payroll Taxes			406,451	406,451		406,451	(1,116)	405,335			22
23	Inservice Training & Education											23
24	Travel and Seminar			33,970	33,970		33,970	(119)	33,851			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			169,404	169,404		169,404	(2,600)	166,804			26
27	Other (specify):* see trial balance			165,198	165,198		165,198	(89,381)	75,817			27
28	TOTAL General Administration	238,943	25,858	1,228,103	1,492,904		1,492,904	(238,112)	1,254,792			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,382,764	383,445	2,394,050	5,160,259		5,160,259	(236,226)	4,924,033			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 Granite Nursing & Rehab Ctr #0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			7,472	7,472		7,472	515,549	523,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,142	4,142		4,142	183,494	187,636			32
33	Real Estate Taxes			89,239	89,239		89,239		89,239			33
34	Rent-Facility & Grounds			388,639	388,639		388,639	(437,574)	(48,935)			34
35	Rent-Equipment & Vehicles			29,753	29,753		29,753		29,753			35
36	Other (specify):*											36
37	**TOTAL Ownership**			519,245	519,245		519,245	261,469	780,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			494	494		494		494			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,399	182,399		182,399		182,399			42
43	Other (specify):* **see trial balance**			218,919	218,919		218,919	(41,452)	177,467			43
44	**TOTAL Special Cost Centers**			401,812	401,812		401,812	(41,452)	360,360			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,382,764	383,445	3,315,107	6,081,316		6,081,316	(16,209)	6,065,107			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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	(5,791)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,120)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(406)	32		10
11	Discounts, Allowances, Rebates & Refunds	(24)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(208)	2		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	(1,748)	21		18
19	Entertainment				19
20	Contributions	(413)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(143,163)	27		24
25	Fund Raising, Advertising and Promotional	(10,440)	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	(3,767)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (168,080)		$	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)	151,871		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 151,871		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (16,209)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Granite Nursing & Rehab Ctr

ID# 0046904

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove non-allowable Visa Cost	$ (119)	24	1
2	Remove non-allowable Admiss-Other Supplies	(2,139)	21	2
3	Remove non-allowable Insurance Cost	(2,600)	26	3
4	Remove non-allowable Outpatient Svcs-Consol Billing	(1,088)	43	4
5	Remove non-allowable BO-Tax Prep Fees	(2,740)	19	5
6	Remove non-allowable Admin-Other Purch Svcs	(1,202)	27	6
7	Remove non-allowable Prior Year Costs	15,390	43	7
8	Remove non-allowable IV Prescription Drugs	(1,195)	43	8
9	Offset Misc. Revenue Sch XVII line 28a	(1,064)	10	9
10	Offset Misc. Revenue Sch XVII line 28a	(31)	10	10
11	Offset Misc. Revenue Sch XVII line 28a	(76)	6	11
12	Offset Misc. Revenue Sch XVII line 28a	(656)	10	12
13	Offset Misc. Revenue Sch XVII line 28a	(207)	10	13
14	Offset Misc. Revenue Sch XVII line 28a	(3)	21	14
15	Offset Interco Sold Service Rev Sch XVII ln 28a	(326)	10	15
16	Offset Interco Sold Service Rev Sch XVII ln 28a	(723)	10	16
17	Offset Interco Sold Service Rev Sch XVII ln 28a	(219)	10	17
18	Offset Interco Sold Service Rev Sch XVII ln 28a	(148)	10	18
19	Offset Interco Sold Service Rev Sch XVII ln 28a	(1,556)	17	19
20	Offset Interco Sold Service Rev Sch XVII ln 28a	(106)	17	20
21	Offset Interco Sold Service Rev Sch XVII ln 28a	(2,176)	10	21
22	Offset Interco Sold Service Rev Sch XVII ln 28a	(1,010)	22	22
23	Offset Outpatient Occupational Therapy Revenue	(2,434)	10a	23
24	Capitalize repairs&maint for Medicaid	(5,753)	6	24
25	Capitalize repairs&maint for Medicaid	(4,606)	6	25
26	Amort/Depreciate Repair/Maint Captl. For Medicaid	13,020	30	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**	(3,767)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(208)	0	0	0	0	0	0	0	0	0	0	(208)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,120)	0	0	0	0	0	0	0	0	0	0	(2,120)	5
6	Maintenance	(10,435)	0	0	0	0	0	0	0	0	0	0	(10,435)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,763)	0	0	0	0	0	0	0	0	0	0	(12,763)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(5,550)	(4,086)	0	0	0	0	0	0	0	0	0	(9,636)	10
10a	Therapy	(8,225)	34,578	0	0	0	0	0	0	0	0	0	26,353	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(2,068)	0	0	0	0	0	0	0	0	0	(2,068)	15
16	**TOTAL Health Care and Programs**	(13,775)	28,424	0	0	0	0	0	0	0	0	0	14,649	16
	C. General Administration													
17	Administrative	(1,662)	(126,140)	0	0	0	0	0	0	0	0	0	(127,802)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,740)	0	0	0	0	0	0	0	0	0	0	(2,740)	19
20	Fees, Subscriptions & Promotions	(10,440)	0	0	0	0	0	0	0	0	0	0	(10,440)	20
21	Clerical & General Office Expenses	(3,914)	0	0	0	0	0	0	0	0	0	0	(3,914)	21
22	Employee Benefits & Payroll Taxes	(1,010)	(106)	0	0	0	0	0	0	0	0	0	(1,116)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(119)	0	0	0	0	0	0	0	0	0	0	(119)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(144,778)	0	55,397	0	0	0	0	0	0	0	0	(89,381)	27
28	**TOTAL General Administration**	(167,263)	(126,246)	55,397	0	0	0	0	0	0	0	0	(238,112)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(193,801)	(97,822)	55,397	0	0	0	0	0	0	0	0	(236,226)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,020	0	502,529	0	0	0	0	0	0	0	0	515,549	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(406)	0	183,900	0	0	0	0	0	0	0	0	183,494	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(437,574)	0	0	0	0	0	0	0	0	(437,574)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	12,614	0	248,855	0	0	0	0	0	0	0	0	261,469	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	13,107	(54,559)	0	0	0	0	0	0	0	0	0	(41,452)	43
44	**TOTAL Special Cost Centers**	13,107	(54,559)	0	0	0	0	0	0	0	0	0	(41,452)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(168,080)	(152,381)	304,252	0	0	0	0	0	0	0	0	(16,209)	45

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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
DTD HC, LLC	50%	White Hall Nursing and Rehabilitation Center, LLC	White Hall	Colonnades Property C	Granite City	Property Company
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Stearns Property Com	Granite City	Property Company
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Hardin Property Com	Hardin	Property Company
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Herculaneum Property	Herculaneum	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Jefferson City Propert	Jefferson City	Property Company
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Riverside Property Co	Kansas City	Property Company
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Terrace Square (Doug	Douglasville	Property Company

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Services Costs	$ 318,888	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 192,748	$ (126,140)	1
2	V								2
3	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	1,532	(2,068)	3
4	V	10	Pharmacy Consulting Services	18,576	Tara Pharmacy SE, LLC	0.00%	16,704	(1,872)	4
5	V	43	Flu Vac/Prescription Drug- Residents	203,633	Tara Pharmacy SE, LLC	0.00%	149,074	(54,559)	5
6	V	22	Flu & Hep B Vaccine for Employees	1,087	Tara Pharmacy SE, LLC	0.00%	981	(106)	6
7	V	10	Medication Administration Records	5,676	Tara Pharmacy SE, LLC	0.00%	3,462	(2,214)	7
8	V	10a	Physical Therapy Fees	344,238	Tara Therapy, LLC	0.00%	351,564	7,326	8
9	V	10a	Occupational Therapy Fees	417,609	Tara Therapy, LLC	0.00%	422,741	5,132	9
10	V	10a	Speech Therapy Fees	168,784	Tara Therapy, LLC	0.00%	190,904	22,120	10
11	V	6	Maintenance Services	1,310	Stearns Nursing and Rehabilitation Center, LLC	0.00%	1,310		11
12	V	1	Dietary Services	9,599	Stearns Nursing and Rehabilitation Center, LLC	0.00%	9,599		12
13	V	15	Nursing Services	884	Granite Nursing and Rehabilitation Center, LLC	0.00%	884		13
14	Total			$ 1,493,884			$ 1,341,503	$ * (152,381)	14

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

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 437,574	Colonnades Property Company, LLC	0.00%	$	$ (437,574)	15
16	V	30	Depreciation Leasehold Imp		Colonnades Property Company, LLC	0.00%	377,402	377,402	16
17	V	30	Depreciation Major Moveable		Colonnades Property Company, LLC	0.00%	36,145	36,145	17
18	V	30	Depreciation Bldg & Improve		Colonnades Property Company, LLC	0.00%	88,982	88,982	18
19	V	27	Amort Loan Acquisition Costs		Colonnades Property Company, LLC	0.00%	55,397	55,397	19
20	V	32	Interest-Capital/Long-Term Debt		Colonnades Property Company, LLC	0.00%	156,479	156,479	20
21	V	32	Interest Expense - M.I.P.		Colonnades Property Company, LLC	0.00%	27,421	27,421	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			$ 437,574			$ 741,826	$ * 304,252	39

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

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			Jonesboro Nursing and Rehabilitation Center, L	Jonesboro	Jonesboro Property Co	Jonesboro	Property Company	1
2			Lake City Nursing and Rehabilitation Center, L	Lake City	Rex Road Property Co	Lake City	Property Company	2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile	Mobile Property Comp	Mobile	Property Company	3
4			Fairfield Nursing and Rehabilitation Center, LL	Fairfield	Fairfield Property Cor	Fairfield	Property Company	4
5			Florence Nursing and Rehabilitation Center, LL	Florence	Florence Property Cor	Florence	Property Company	5
6			Birmingham Nrs&Rehab Center East, LLC	Birmingham	Birmingham East Prop	Birmingham	Property Company	6
7			Birmingham Nursing and Rehabilitation Center	Birmingham	Birmingham Property	Birmingham	Property Company	7
8			Eight Mile Nursing and Rehabilitation Center, L	Eight Mile	Eight Mile Property C	Eight Mile	Property Company	8
9			Quince Nursing and Rehabilitation Center, LLC	Memphis	Quince Property Comp	Memphis	Property Company	9
10			Allenbrooke Nursing and Rehabilitation Center,	Memphis	Allenbrooke Property	Memphis	Property Company	10
11			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo	Tupelo Property Comp	Tupelo	Property Company	11
12			Brandon Nursing and Rehabilitation Center, LL	Brandon	Brandon Property Cor	Brandon	Property Company	12
13			Lakeland Nursing and Rehabilitation Center, LI	Jackson	Lakeland Property Co	Jackson	Property Company	13
14			McComb Nursing and Rehabilitation Center, LI	McComb	McComb Property Co	McComb	Property Company	14
15			Cleveland Nursing and Rehabilitation Center, L	Cleveland	Cleveland Property Co	Cleveland	Property Company	15
16			Chadwick Nursing and Rehabilitation Center, L	Jackson	Chadwick (Jackson) P	Jackson	Property Company	16
17			Manhattan Nursing and Rehabilitation Center, I	Jackson	Manhattan Property C	Jackson	Property Company	17
18			Ruleville Nursing and Rehabilitation Center, LL	Ruleville	Ruleville Property Cor	Ruleville	Property Company	18
19			Farmerville Nursing and Rehabilitation Center,	Farmerville	Farmerville Property (	Farmerville	Property Company	19
20			Bernice Nursing and Rehabilitation Center, LLC	Bernice	Bernice Property Com	Bernice	Property Company	20
21			Ruston Nursing and Rehabilitation Center, LLC	Ruston	Longleaf (Ruston) Pro	Ruston	Property Company	21
22			Natchitoches Nursing and Rehabilitation Center	Natchitoches	Natchitoches Property	Natchitoches	Property Company	22
23			Winnfield Nursing and Rehabilitation Center, L	Winnfield	Winnfield Property Co	Winnfield	Property Company	23
24			Ringgold Nursing and Rehabilitation Center, LI	Ringgold	Ringgold Property Cor	Ringgold	Property Company	24
25			Arcadia Nursing and Rehabilitation Center, LL	Arcadia	Willow Ridge (Arcadia	Arcadia	Property Company	25
26			Jena Nursing and Rehabilitation Center, LLC	Jena	Aimwell (Jena) Proper	Jena	Property Company	26
27					Aurora Cares Property	Orchard Park	Property Company	27
28			** The above listed facilites are related by		Aurora Cares, LLC d/	Orchard Park	Support Office	28
29			common ownership		Tara Midwest, LLC	Orchard Park	Clearing Account fo	29
30					Tara Healthcare, LLC	Orchard Park	Clearing Account fo	30

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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					Tara Pharmacy SE, LI	Birmingham	Pharmacy	1
2					Tara Therapy, LLC	Orchard Park	Therapy	2
3					Raimax Healthcare So	Orchard Park	Software	3
4					White Hall Property C	White Hall	Property Company	4
5					3690 N. H. Associates,	Orchard Park	Clearing Account fo	5
6					3690 Associates, LLC	Orchard Park	Clearing Account fo	6
7					Health Care Risk Grou	Orchard Park	Insurance	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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.58	1.45	Fin/Adm. TC	4,028	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.58	1.45	Fin/Adm. TC	4,028	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.58	1.45	VP	3,343	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										9
10											10
11											11
12											12
13								TOTAL	$ 11,399		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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 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 [X] NO [ ]

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

Name of Related Organization: Aurora Cares, LLC d/b/a Tara Cares
Street Address: PO Box 428
City / State / Zip Code: Orchard Park, NY 14127
Phone Number: (716)662-4955
Fax Number: (716)662-2529

	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	Administrative Services Costs	Days	1,473,669	35	$ 257,223	$ 220,671	26,789	$ 4,676	1
2	5	Administrative Services Costs	Days	1,473,669	35	36,825	0	26,789	669	2
3	6	Administrative Services Costs	Days	1,473,669	35	55,513	0	26,789	1,009	3
4	10	Administrative Services Costs	Days	1,473,669	35	2,440,929	2,173,122	26,789	44,371	4
5	17	Administrative Services Costs	Days	1,473,669	35	5,663,604	5,663,604	26,789	102,952	5
6	19	Administrative Services Costs	Days	1,473,669	35	9,265	0	26,789	168	6
7	20	Administrative Services Costs	Days	1,473,669	35	14,781	0	26,789	269	7
8	21	Administrative Services Costs	Days	1,473,669	35	305,257	0	26,789	5,549	8
9	22	Administrative Services Costs	Days	1,473,669	35	1,272,672	0	26,789	23,135	9
10	24	Administrative Services Costs	Days	1,473,669	35	113,930	0	26,789	2,071	10
11	26	Administrative Services Costs	Days	1,473,669	35	5,104	0	26,789	93	11
12	27	Administrative Services Costs	Days	1,473,669	35	133,549	0	26,789	2,428	12
13	30	Administrative Services Costs	Days	1,473,669	35	154,779	0	26,789	2,814	13
14	31	Administrative Services Costs	Days	1,473,669	35	4,919	0	26,789	89	14
15	32	Administrative Services Costs	Days	1,473,669	35	91	0	26,789	2	15
16	33	Administrative Services Costs	Days	1,473,669	35	28,086	0	26,789	511	16
17	34	Administrative Services Costs	Days	1,473,669	35	106,649	0	26,789	1,939	17
18	35	Administrative Services Costs	Days	1,473,669	35	173	0	26,789	3	18
19										19
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								21
22		considered a Home Office by CMS and as defined in 42 CRF 421.404.								22
23										23
24										24
25	TOTALS					$ 10,603,349	$ 8,057,397		$ 192,748	25

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	M&T BANK		X	Purchase of Physical Plant	$14,788.46	6/22/11	$ 4,459,331	$	6/20/12	libor+3.5%	$ 81,337	1
2	Lancaster Pollard Mortgage Company		X	Refinance Purchase of Plant	$19,274.50	6/20/12	5,194,800	5,157,782	7/1/47	0.0275	75,143	2
3												3
4												4
5												5
	Working Capital											
6	M&T BANK		X	Working Capital-Floating Balar	$294.00	6/26/09	4,495	100,418	demand not	0.0450	3,526	6
7												7
8												8
9	TOTAL Facility Related				$34,356.96		$ 9,658,626	$ 5,258,200			$ 160,006	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,658,626	$ 5,258,200			$ 160,006	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 13,393 Line # 34

*** 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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	88,130	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.)	$	86,519	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,611)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	90,850	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.	$	89,239	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007	70,786	8
2008	79,663	9
2009	81,853	10
2010	83,929	11
2011	86,519	12

	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Granite Nursing & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046904

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

TELEPHONE (716) 662-4955, ext 392 FAX #: (716) 662-4468

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-2-20-07-08-201-010	3500 Century Dr. Lot 1	$ 81,169.80	$ 81,169.80
2.	22-2-20-07-08-201-011	3500 Century Dr. Lot 2	$ 5,348.96	$ 5,348.96
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 86,518.76	$ 86,518.76

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 X 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.

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,856 B. General Construction Type: Exterior Brick Frame _____ Number of Stories one

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 131,730
2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: Included in Schedule VII B Ln 1-8
4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc.CapitalizedPre-openingSalaries,Benefits&OtherCostsIncurred2007,2009&2010.AllocatedViaRelatedOrgCost&ReportedSchVII B
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long Term Care	503,833	2011	$ 309,970	1
2					2
3	TOTALS	503,833		$ 309,970	3

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	86		2011	1964	$ 3,559,279	$ 88,982	40	$ 88,982	$	$ 133,473	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing and Mechanical repairs capitalized for Medicaid			2005	7,645		3			7,645	9
10	Paint - Kitchen			2006	4,500		5			4,500	10
11	Paint Center of Building			2006	37,005		5			37,004	11
12	Window Treatment			2006	5,089		5			5,089	12
13	20 Ton HVAC Unit			2006	20,160	2,016	10	2,016		13,104	13
14	Sprinkler System			2006	232,098	19,342	12	19,342		125,721	14
15	Emergency Lighting			2006	2,034	169	12	169		1,101	15
16	Weatherproof Lighting			2006	5,470	456	12	456		2,963	16
17	Exhaust Hood			2006	8,017	668	12	668		4,342	17
18	Sign			2006	800	80	10	80		520	18
19	Utility Room Cabinet			2006	2,946	245	12	245		1,595	19
20	Plumbing and Mechanical repairs capitalized for Medicaid			2006	16,108		3			16,108	20
21	2 Sprinkler System Heads			2007	1,578	143	11	143		788	21
22	Concrete Sidewalk			2007	2,470	247	10	247		1,359	22
23	Mag Locks and Key Pads			2007	2,604	260	10	260		1,431	23
24	Physical Therapy Addition			2007	431,389	39,217	11	39,217		215,694	24
25	Plumbing and Mechanical repairs capitalized for Medicaid			2007	20,861		3			20,861	25
26	Generator			2007	146,483	29,297	5	29,297		131,835	26
27	Mechanical/Electrical Systems Upgrade & Significant Bldg Improvements			2008	1,623,449	162,345	10	162,345		730,553	27
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails										28
29	Dry Pendants			2008	3,020	302	10	302		1,359	29
30	Window Treatments			2008	30,741	6,148	5	6,148		27,666	30
31	Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2			2008	882,074	88,207	10	88,207		396,932	31
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track										32
33	Facility Sign			2008	12,836	1,284	10	1,284		5,777	33
34	Roof			2008	132,870	13,287	10	13,287		59,792	34
35	Physical Therapy Costs capitalized for Medicaid			2008	6,100		3			6,100	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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 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	
37	Sewer Ejector Pump	2009	$ 9,950	$ 1,106	9	$ 1,106	$	$ 3,870	37
38	Boiler Assessment (Asset #120 Addition)	2009	11,439	1,271	9	1,271		4,449	38
39	Satellite TV Equipment	2009	12,830	1,426	9	1,426		4,990	39
40	Garage Door	2009	662	74	9	74		258	40
41	Generator and Carrier Air Handler rpr Capitalized for Medicaid	2009	6,331	1,056	3	1,056		6,331	41
42	Boiler System Replacement	2010	73,440	9,180	8	9,180		22,950	42
43	A/C Unit (4)	2010	2,291	458	5	458		1,145	43
44	Concrete repairs to exits/stairwells-Capitalized for Medicaid	2010	13,900	4,634	3	4,634		11,584	44
45	Boiler System Repair Capitalized for Medicaid	2010	3,442	1,147	3	1,147		2,868	45
46	Sewage Pump	2011	1,219	174	7	174		261	46
47	Boiler/Heater/Call Light System rpr Capitalized for Medicaid	2011	13,367	4,456	3	4,456		6,684	47
48	Kwalu-Wall Covering/protection	2012	2,595	87	15	87		87	48
49	(3) PTAC Units	2012	1,865	186	5	186		186	49
50	Concrete Catch Basin	2012	3,110	104	15	104		104	50
51	Piping and Floor Drain	2012	935	17	25	17		17	51
52	Concrete Patio & Storm Drain	2012	46,184	1,539	15	1,539		1,539	52
53	FireSystemRpr&SmokeDetectorReplace-Capitalized for Medicaid	2012	5,753	959	3	959		959	53
54	SewerPipeCableing/DrainCleaning-Capitalized for Medicaid	2012	4,606	768	3	768		768	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Note: See additional building improvements made by former								63
64	property owner Healthcare REIT, Inc. on supplemental								64
65	schedule included as page 24 of the cost report.								65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,411,543	$ 481,337		$ 481,337	$	$ 2,022,362	70

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

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 297,481	$ 38,397	$ 38,397	$	various	$ 157,194	71
72	Current Year Purchases	35,227	3,287	3,287		various	3,287	72
73	Fully Depreciated Assets	60,926				various	60,926	73
74								74
75	TOTALS	$ 393,634	$ 41,684	$ 41,684	$		$ 221,407	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	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,115,147	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 523,021	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 523,021	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,243,769	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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:	N/A	N/A	N/A	$ N/A	N/A	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2013	$ N/A
13.	/2014	$ N/A
14.	/2015	$ N/A

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: N/A *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 29,127 Description: see separate 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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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
   - [X] 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)	$			

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.

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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		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):									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.

Facility Name & ID Number Granite Nursing & Rehab Ctr **#** 0046904 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/12 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 430,506	$	1
2	Cash-Patient Deposits	22,005		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	878,199		3
4	Supply Inventory (priced at cost)	8,048		4
5	Short-Term Investments			5
6	Prepaid Insurance	376		6
7	Other Prepaid Expenses	9,812		7
8	Accounts Receivable (owners or related parties)	(3,859,718)		8
9	Other(specify): Non resident A/R (see TB)	2,609		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,508,163)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	54,689		15
16	Equipment, at Historical Cost	45,618		16
17	Accumulated Depreciation (book methods)	(8,597)		17
18	Deferred Charges	1,849		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(69)		21
22	Other Long-Term Assets (spe Deposits-Long Term	1,200		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 94,690	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (2,413,473)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 115,674	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,239		28
29	Short-Term Notes Payable	100,418		29
30	Accrued Salaries Payable	217,481		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,523		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,695		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	11,096		36
37	Accrued Expenses	339,799		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 872,925	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 872,925	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,286,398)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (2,413,473)	$	48

***(See instructions.)**

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,853,058)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,853,058)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(300,339)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	44,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(177,001)	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)**	$ (433,340)	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)**	$ (3,286,398)	24 *

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

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,593,906	1
2	Discounts and Allowances for all Levels	1,319,175	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,913,081	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	8,225	5
6	Therapy	774,451	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 782,676	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	2,120	15
16	Rental of Facility Space		16
17	Sale of Drugs	3,117	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,333	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,570	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	406	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 406	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	67,420	28
28a	Purchase Discounts & Misc Revenue	9,824	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 77,244	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,780,977	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	737,970	31
32	Health Care	2,929,385	32
33	General Administration	1,492,904	33
	B. Capital Expense		
34	Ownership	519,245	34
	C. Ancillary Expense		
35	Special Cost Centers	219,413	35
36	Provider Participation Fee	182,399	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,081,316	40
41	**Income before Income Taxes (line 30 minus line 40)****	(300,339)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (300,339)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,407,733	44
45	Private Pay - Net Inpatient Revenue	965,669	45
46	Medicare - Net Inpatient Revenue	2,239,792	46
47	Other-(specify) Hospice Contract	299,887	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,913,081	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? see attached 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 Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,080	$ 86,094	$ 41.39	1
2	Assistant Director of Nursing	1,972	2,032	58,511	28.79	2
3	Registered Nurses	4,174	4,583	124,850	27.24	3
4	Licensed Practical Nurses	27,763	29,604	642,681	21.71	4
5	CNAs & Orderlies	58,679	63,511	688,390	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,771	1,914	20,009	10.45	9
10	Activity Assistants	884	914	7,668	8.39	10
11	Social Service Workers	1,768	1,903	32,035	16.83	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,080	32,454	15.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,413	3,609	32,603	9.03	15
16	Dishwashers	9,431	10,221	89,176	8.72	16
17	Maintenance Workers	1,505	1,672	24,395	14.59	17
18	Housekeepers	12,842	14,068	127,736	9.08	18
19	Laundry	1,449	1,722	16,198	9.41	19
20	Administrator	1,908	2,657	104,978	39.51	20
21	Assistant Administrator					21
22	Other Administrative	3,891	4,215	67,992	16.13	22
23	Office Manager	1,893	2,057	41,579	20.21	23
24	Clerical	1,625	2,105	24,394	11.59	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					31
32	Other Health Care(specify)	3,889	4,364	100,655	23.06	32
33	Other(specify)	3,996	4,462	60,366	13.53	33
34	TOTAL (lines 1 - 33)	146,701	159,773	$ 2,382,764 *	$ 14.91	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	636	9,600	9-3	36
37	Medical Records Consultant	48	2,976	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18 per bed/mo	18,576	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,530	11-3	44
45	Social Service Consultant	26	1,530	12-3	45
46	Other(specify)				46
47	Medical Adm Record Preparation	$5.50 per bed/mo	5,676	10-3	47
48					48
49	TOTAL (lines 35 - 48)	736	$ 39,888		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Jeffries	Administrator	0	$ 75,438
Vickie Summers	Administrator	0	20,262
Lewis Schweizer	Administrator	0	9,278
Laura Barton	Bus. Office Mgr	0	41,579
Barbara J. Colp	AP/Payroll	0	24,394
Cherrell Gallion	Human Resources	0	32,636
Dawn Steward	Admiss. Coordinator	0	35,356
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 238,943

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 318,888
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 318,888

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,437
Freed, Maxick & Battaglia	Tax Fees	2,740
Various Legal Fees - See attached list	detailed listing	72,604
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 77,781

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ (37,324)
Unemployment Compensation Insurance	107,852
FICA Taxes	178,859
Employee Health Insurance	142,201
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Sefety Rec. Program	1,750
Employee Benefits - Other	11,326
Emplyee Benefit - Short Term Disability	671
TOTAL (agree to Schedule V, line 22, col.8)	$ 405,335

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

Description	Line #	Amount
None in Allowable cost (Column 8) of Schedule V		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,989
Advertising: Employee Recruitment	2,353
Health Care Worker Background Check	8,110
(Indicate # of checks performed 353)	
Patient Background Checks 127	
Facility Advertising	6,454
IL Health Care Association Dues	4,747
Non-AllowableDues & Subscriptions	(3,986)
Administator/Business License	225
Chamber of Commerce	795
Less: Public Relations Expense	( )
Non-allowable advertising	(6,454)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,233

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	29,253
Seminar Expense	4,598
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,851

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Granite Nursing & Rehab Ctr # 0046904 Report Period Beginning: 1/1/12 Ending: 12/31/12

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $1,556 net of non allowable**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **29,834** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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 Departmen
during this cost report period. $ **182,399**
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 tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **Yes-outpatient therap** 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. $ **None** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1			$	$		$	$	$	1
2	Improvements Made by Healthcare REIT (covered by rent at outset								2
3	of Change of Ownership)								3
4									4
5	Aspire Telephone System	2005	7,542	754	10	754		5,656	5
6	Garage Door	2005	536	53	10	53		402	6
7	Ductwork Removal & Installation	2005	10,635	818	13	818		6,136	7
8	Replace Plumbing & Garbage Disposal	2005	6,767	520	13	520		3,904	8
9	Exhaust Fan - Laundry Area	2005	855	86	10	86		641	9
10	Doors (6)	2005	6,800	523	13	523		3,923	10
11	Air Conditioning Units (3)	2005	3,294		5			3,294	11
12	Carpeting	2005	587		5			587	12
13	Roof Repairs - New Gutters and Facia	2005	4,850	485	10	485		3,637	13
14	Fire Damper	2005	1,250	125	10	125		937	14
15	Pave Walkway	2005	5,714	714	8	714		5,357	15
16	Replace 140' Sewer & Floor	2005	39,530	3,041	13	3,041		22,806	16
17	Floor Replacement Cost @ 6/30/06	2006	17,434	1,320	10	1,320		8,578	17
18	Floor Replacement Addl Cost Post 6/30/06	2006	(4,237)						18
19	Walk-in Cooler / Freezer	2006	31,667	2,639	12	2,639		17,153	19
20	Paint Exterior of Facility	2006	3,847		5			3,847	20
21	Plumbing Install Sinks (2)	2006	18,500	1,542	12	1,542		10,021	21
22	Carpeting	2006	1,639		5			1,639	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)		$ 157,209	$ 12,620		$ 12,620	$ 0	$ 98,518	34

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