		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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:** 0046904

Facility Name: Granite Nsg & Rehab Center

Address: 3500 Century Drive (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
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

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 1/1/13 to 12/31/13 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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	31,390	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	31,390	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	14,318	5,886	6,075	26,279	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,318	5,886	6,075	26,279	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.72%

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)

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 01/01/2005

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 4,508

Medicare Intermediary Wisconsin Physicials Insurance Corp.

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 12/31/13 Fiscal Year: 1/1 to 12/31/13

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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	151,084	16,011	21,937	189,032		189,032		189,032			1
2	Food Purchase		169,973		169,973		169,973	(896)	169,077			2
3	Housekeeping	113,229	18,494	406	132,129		132,129		132,129			3
4	Laundry	24,486	11,517		36,003		36,003		36,003			4
5	Heat and Other Utilities			92,169	92,169		92,169	(1,940)	90,229			5
6	Maintenance	38,158	19,993	49,236	107,387		107,387	(4,000)	103,387			6
7	Other (specify):* see trial balance			41,112	41,112		41,112		41,112			7
8	**TOTAL General Services**	326,957	235,988	204,860	767,805		767,805	(6,836)	760,969			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,664,677	124,313	22,567	1,811,557		1,811,557	(8,303)	1,803,254			10
10a	Therapy		7,103	745,375	752,478		752,478	35,897	788,375			10a
11	Activities	25,797	512	2,841	29,150		29,150		29,150			11
12	Social Services	36,739	45	1,543	38,327		38,327		38,327			12
13	CNA Training											13
14	Program Transportation			11,455	11,455		11,455		11,455			14
15	Other (specify):* see trial balance			11,576	11,576		11,576	(637)	10,939			15
16	**TOTAL Health Care and Programs**	1,727,213	131,973	804,957	2,664,143		2,664,143	26,957	2,691,100			16
	C. General Administration											
17	Administrative	245,725		324,912	570,637		570,637	(160,466)	410,171			17
18	Directors Fees											18
19	Professional Services			158,755	158,755		158,755	(2,369)	156,386			19
20	Dues, Fees, Subscriptions & Promotions			30,444	30,444		30,444	(18,014)	12,430			20
21	Clerical & General Office Expenses		37,558	40,418	77,976		77,976	(17,809)	60,167			21
22	Employee Benefits & Payroll Taxes			442,524	442,524		442,524	(3,324)	439,200			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,470	18,470		18,470	(20)	18,450			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			66,982	66,982		66,982	(2,600)	64,382			26
27	Other (specify):* see trial balance			38,446	38,446		38,446	(11,359)	27,087			27
28	**TOTAL General Administration**	245,725	37,558	1,120,951	1,404,234		1,404,234	(215,961)	1,188,273			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,299,895	405,519	2,130,768	4,836,182		4,836,182	(195,840)	4,640,342			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 Nsg & Rehab Center #0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			16,246	16,246		16,246	493,282	509,528			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,568	5,568		5,568	151,848	157,416			32
33	Real Estate Taxes			98,796	98,796		98,796		98,796			33
34	Rent-Facility & Grounds			307,449	307,449		307,449	(307,449)				34
35	Rent-Equipment & Vehicles			34,507	34,507		34,507		34,507			35
36	Other (specify):*											36
37	**TOTAL Ownership**			462,566	462,566		462,566	337,681	800,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			527	527		527		527			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,235	179,235		179,235		179,235			42
43	Other (specify):* **see trial balance**			263,417	263,417		263,417	(91,500)	171,917			43
44	**TOTAL Special Cost Centers**			443,179	443,179		443,179	(91,500)	351,679			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,299,895	405,519	3,036,513	5,741,927		5,741,927	50,341	5,792,268			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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	(1,303)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,940)	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	(29,201)	32		10
11	Discounts, Allowances, Rebates & Refunds	(234)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(172)	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	(8,343)	21		18
19	Entertainment				19
20	Contributions	(1,000)	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	(15,824)	27		24
25	Fund Raising, Advertising and Promotional	(17,964)	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	(56,479)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (132,460)		$	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)	182,801		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 182,801		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 50,341		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 Nsg & Rehab Center

ID# 0046904

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove non-allowable Admiss - Prof Dues	$ (50)	20	1
2	Remove non-allowable Visa Costs	(20)	24	2
3	Remove non-allowable Admiss - Other Supplies	(9,180)	21	3
4	Remove non-allowable Insurance Costs	(2,600)	26	4
5	Remove non-allow Outpatient Svcs Consol Billing	(1,172)	43	5
6	Remove non-allow Nrs Admin Purch Services	(662)	15	6
7	Remove non-allow Accounting Tax Fees	(2,369)	19	7
8	Remove non-allowable Admin Purchased Services	(33)	27	8
9	Remove non-allowable Prior Year Costs	(8,998)	43	9
10	Remove non-allowable IV Prescription Drugs	(11,920)	43	10
11	Offset Interco Sold Service Rev Sch XVII ln 28a	(47)	6	11
12	Offset Interco Sold Service Rev Sch XVII ln 28a	(1,114)	10	12
13	Offset Interco Sold Service Rev Sch XVII ln 28a	(2,338)	10	13
14	Offset Interco Sold Service Rev Sch XVII ln 28a	(3,186)	17	14
15	Offset Interco Sold Service Rev Sch XVII ln 28a	(9,584)	17	15
16	Offset Interco Sold Service Rev Sch XVII ln 28a	(1,066)	17	16
17	Offset Interco Sold Service Rev Sch XVII ln 28a	(2,979)	22	17
18	Offset Misc. Revenue Sch XVII line 28a	(1,274)	10	18
19	Offset Misc. Revenue Sch XVII line 28a	(78)	10	19
20	Offset Misc. Revenue Sch XVII line 28a	(223)	6	20
21	Offset Misc. Revenue Sch XVII line 28a	(846)	10	21
22	Offset Misc. Revenue Sch XVII line 28a	(82)	10	22
23	Offset Misc. Revenue Sch XVII line 28a	(3)	21	23
24	Offset Outpatient Occupational Therapy Revenue	(3,650)	10a	24
25	Capitalize repairs & maintenance for Medicaid	(4,359)	6	25
26	Amort/Depreciate Repair/Maint Captl. For Medcaid	11,527	30	26
27	Remove Non-allowable Admin Other Supplies	(49)	21	27
28	Accrue Addtl Allowable Plant Ops Other Supplies	629	6	28
29	Remove Non-allowable Dietary Raw Food	(724)	2	29
30	Remove Non-allowable Depreciation Exp on LHI	(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**	(56,479)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nsg & Rehab Center **#** 0046904 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(896)	0	0	0	0	0	0	0	0	0	0	(896)	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	(1,940)	0	0	0	0	0	0	0	0	0	0	(1,940)	5
6	Maintenance	(4,000)	0	0	0	0	0	0	0	0	0	0	(4,000)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,836)	0	0	0	0	0	0	0	0	0	0	(6,836)	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	(5,732)	(2,571)	0	0	0	0	0	0	0	0	0	(8,303)	10
10a	Therapy	(4,953)	40,850	0	0	0	0	0	0	0	0	0	35,897	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):*	(662)	25	0	0	0	0	0	0	0	0	0	(637)	15
16	**TOTAL Health Care and Programs**	(11,347)	38,304	0	0	0	0	0	0	0	0	0	26,957	16
	C. General Administration													
17	Administrative	(13,836)	(146,630)	0	0	0	0	0	0	0	0	0	(160,466)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,369)	0	0	0	0	0	0	0	0	0	0	(2,369)	19
20	Fees, Subscriptions & Promotions	(18,014)	0	0	0	0	0	0	0	0	0	0	(18,014)	20
21	Clerical & General Office Expenses	(17,809)	0	0	0	0	0	0	0	0	0	0	(17,809)	21
22	Employee Benefits & Payroll Taxes	(2,979)	(345)	0	0	0	0	0	0	0	0	0	(3,324)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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):*	(16,857)	0	5,498	0	0	0	0	0	0	0	0	(11,359)	27
28	**TOTAL General Administration**	(74,484)	(146,975)	5,498	0	0	0	0	0	0	0	0	(215,961)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(92,667)	(108,671)	5,498	0	0	0	0	0	0	0	0	(195,840)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	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)	
30	Depreciation	11,498	0	481,784	0	0	0	0	0	0	0	0	493,282	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,201)	0	181,049	0	0	0	0	0	0	0	0	151,848	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(307,449)	0	0	0	0	0	0	0	0	(307,449)	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**	(17,703)	0	355,384	0	0	0	0	0	0	0	0	337,681	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):*	(22,090)	(69,410)	0	0	0	0	0	0	0	0	0	(91,500)	43
44	**TOTAL Special Cost Centers**	(22,090)	(69,410)	0	0	0	0	0	0	0	0	0	(91,500)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(132,460)	(178,081)	360,882	0	0	0	0	0	0	0	0	50,341	45

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Aurora Cares, LLC d/	Orchard Park	Support Office
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	3690 N. H. Associates,	Orchard Park	Clearing Account
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Hardin Property Com	Hardin	Property Company
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Health Care Risk Gro	Orchard Park	Insurance
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Tara Pharmacy SE, L	Birmingham	Pharmacy
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Tara Therapy, LLC	Orchard Park	Therapy
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Raimax Healthcare So	Orchard Park	Software

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	$ 324,912	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 178,282	$ (146,630)	1
2	V	15	Wireless Access Points License Fee	623	Raimax Healthcare Solutions Group, LLC	0.00%	2,957	2,334	2
3	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	1,291	(2,309)	3
4	V	27	Service to replace switches	1,428	Raimax Healthcare Solutions Group, LLC	0.00%	1,428		4
5	V	10	Pharmacy Consulting Services	18,576	Tara Pharmacy SE, LLC	0.00%	16,609	(1,967)	5
6	V	43	Flu Vac/Prescription Drug- Residents	221,521	Tara Pharmacy SE, LLC	0.00%	152,111	(69,410)	6
7	V	22	Flu & Hep B Vaccine for Employees	1,140	Tara Pharmacy SE, LLC	0.00%	795	(345)	7
8	V	10	Medication Administration Records	946	Tara Pharmacy SE, LLC	0.00%	342	(604)	8
9	V	10a	Physical Therapy Fees	268,667	Tara Therapy, LLC	0.00%	285,739	17,072	9
10	V	10a	Occupational Therapy Fees	329,540	Tara Therapy, LLC	0.00%	336,039	6,499	10
11	V	10a	Speech Therapy Fees	145,749	Tara Therapy, LLC		163,028	17,279	11
12	V								12
13	V								13
14	Total			$ 1,316,702			$ 1,138,621	$ * (178,081)	14

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 307,449	Colonnades Property Company, LLC	0.00%	$	$ (307,449)	15
16	V	30	Depreciation Leasehold Imp		Colonnades Property Company, LLC	0.00%	359,680	359,680	16
17	V	30	Depreciation Major Moveable		Colonnades Property Company, LLC	0.00%	33,122	33,122	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%	5,498	5,498	19
20	V	32	Interest-Capital/Long-Term Debt		Colonnades Property Company, LLC	0.00%	140,495	140,495	20
21	V	32	Interest Expense - M.I.P.		Colonnades Property Company, LLC	0.00%	40,554	40,554	21
22	V								22
23	V	27	Admissions Services	463	Allenbrooke Nursing and Rehabilitation Center, LLC	0.00%	463		23
24	V	6	Maintenance Services	15,239	Allenbrooke Nursing and Rehabilitation Center, LLC	0.00%	15,239		24
25	V	1	Dietary Services	1,048	Scenic Nursing and Rehabilitation Center, LLC	0.00%	1,048		25
26	V	3	Housekeeping Services	248	Scenic Nursing and Rehabilitation Center, LLC	0.00%	248		26
27	V	6	Maintenance Services	111	Scenic Nursing and Rehabilitation Center, LLC	0.00%	111		27
28	V	1	Dietary Services	421	White Hall Nursing and Rehabilitation Center, LLC	0.00%	421		28
29	V	15	Nursing Services	440	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	440		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			$ 325,419			$ 686,301	$ * 360,882	39

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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				1
2			Lake City Nursing and Rehabilitation Center, LL	Lake City				2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile				3
4			Florence Nursing and Rehabilitation Center, LL	Florence				4
5			Birmingham Nrs&Rehab Center East, LLC	Birmingham				5
6			Birmingham Nursing and Rehabilitation Center,	Birmingham				6
7			Eight Mile Nursing and Rehabilitation Center, L	Eight Mile				7
8			North Hill Nursing and Rehabilitation Center, L	North Hill				8
9			Elba Nursing and Rehabilitation Center, LLC	Elba				9
10			Quince Nursing and Rehabilitation Center, LLC	Memphis				10
11			Allenbrooke Nursing and Rehabilitation Center,	Memphis				11
12			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo				12
13			Brandon Nursing and Rehabilitation Center, LL	Brandon				13
14			Lakeland Nursing and Rehabilitation Center, LI	Jackson				14
15			McComb Nursing and Rehabilitation Center, LI	McComb				15
16			Cleveland Nursing and Rehabilitation Center, L	Cleveland				16
17			Chadwick Nursing and Rehabilitation Center, L	Jackson				17
18			Manhattan Nursing and Rehabilitation Center, I	Jackson				18
19			Ruleville Nursing and Rehabilitation Center, LL	Ruleville				19
20			Farmerville Nursing and Rehabilitation Center,	Farmerville				20
21			Bernice Nursing and Rehabilitation Center, LLC	Bernice				21
22			Ruston Nursing and Rehabilitation Center, LLC	Ruston				22
23			Natchitoches Nursing and Rehabilitation Center	Natchitoches				23
24			Winnfield Nursing and Rehabilitation Center, L	Winnfield				24
25			Ringgold Nursing and Rehabilitation Center, LI	Ringgold				25
26			Arcadia Nursing and Rehabilitation Center, LL	Arcadia				26
27			Jena Nursing and Rehabilitation Center, LLC	Jena				27
28								28
29			** The above listed facilites are related by					29
30			common ownership					30

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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	***	0.57	1.43	Fin/ Adm. of TC	4,106	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.57	1.43	Fin/ Adm. of TC	4,106	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.57	1.43	VP of TC	3,334	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	$ 11,546		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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Total Costs	353,161,911	41	$ 346,431	$ 263,368	5,385,401	$ 5,282	1
2	5	Administrative Services Costs	Days	1,476,622	37	41,284	0	26,258	735	2
3	6	Administrative Services Costs	Days	1,476,622	37	71,472	0	26,258	1,272	3
4	10	Administrative Services Costs	Total Costs	353,161,911	41	3,382,826	2,681,559	5,385,401	51,593	4
5	17	Administrative Services Costs	Days	1,476,622	37	5,196,557	5,196,557	26,258	92,403	5
6	19	Administrative Services Costs	Days	1,476,622	37	31,367	0	26,258	557	6
7	20	Administrative Services Costs	Days	1,476,622	37	12,440	0	26,258	222	7
8	21	Administrative Services Costs	Days	1,476,622	37	241,710	0	26,258	4,297	8
9	22	Administrative Services Costs	Days	1,476,622	37	802,842	0	26,258	14,277	9
10	24	Administrative Services Costs	Days	1,476,622	37	105,969	0	26,258	1,885	10
11	26	Administrative Services Costs	Days	1,476,622	37	7,389	0	26,258	131	11
12	27	Administrative Services Costs	Days	1,476,622	37	62,648	0	26,258	1,113	12
13	30	Administrative Services Costs	Days	1,476,622	37	165,080	0	26,258	2,936	13
14	31	Administrative Services Costs	Days	1,476,622	37	10,708	0	26,258	190	14
15	32	Administrative Services Costs	Days	1,476,622	37	278	0	26,258	5	15
16	33	Administrative Services Costs	Days	1,476,622	37	29,222	0	26,258	520	16
17	34	Administrative Services Costs	Days	1,476,622	37	47,896	0	26,258	851	17
18	35	Administrative Services Costs	Days	1,476,622	37	718	0	26,258	13	18
19										19
20										20
21		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								21
22		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								22
23		considered a Home Office by CMS and as defined in 42 CRF 421.404.								23
24										24
25	TOTALS					$ 10,556,837	$ 8,141,484		$ 178,282	25

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Lancaster Pollard Mortgage Company		X	Refinance purchase of plant	$21,662.25	6/20/12	$ 5,194,800	$ 5,067,191	7/1/47	0.0275	$ 140,495	1
2												2
3												3
4												4
5												5
	Working Capital											
6	M&T BANK		X	Working Capital - Floating Bal	$361.25	6/26/09	4,495	82,418	demand not	0.0450	4,335	6
7												7
8												8
9	TOTAL Facility Related				$22,023.50		$ 5,199,295	$ 5,149,609			$ 144,830	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,199,295	$ 5,149,609			$ 144,830	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,338 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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	90,850	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.)	$	92,506	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,656	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	97,200	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	$	98,856	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	79,663	8
	2009	81,853	9
	2010	83,929	10
	2011	86,519	11
	2012	92,506	12

The 2013 assessment was estimated to be a 5% increase over the 2012 assessment.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Granite Nsg & Rehab Center 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 2012 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 2012.

	(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	$ 87,872.56	$ 87,872.56
2.	22-2-20-07-08-201-011	3500 Century Dr. Lot 2	$ 4,633.92	$ 4,633.92
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 92,506.48	$ 92,506.48

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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? [X] (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: 136,427 2. Number of Years Over Which it is Being Amortized: 5 yers (60 Months)

3. Current Period Amortization: Included in Schedule VII B ln 1-8 4. Dates Incurred: Various and on the books of 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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$	$ 222,455	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			37,005	11
12	Window Treatment			2006	5,089		5			5,089	12
13	20 Ton HVAC Unit			2006	20,160	2,016	10	2,016		15,120	13
14	Sprinkler System			2006	232,098	19,342	12	19,342		145,062	14
15	Emergency Lighting			2006	2,034	169	12	169		1,271	15
16	Weatherproof Lighting			2006	5,470	456	12	456		3,419	16
17	Exhaust Hood			2006	8,017	668	12	668		5,010	17
18	Sign			2006	800	80	10	80		600	18
19	Utility Room Cabinet			2006	2,946	246	12	246		1,841	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		932	21
22	Concrete Sidewalk			2007	2,470	247	10	247		1,606	22
23	Mag Locks and Key Pads			2007	2,604	260	10	260		1,692	23
24	Physical Therapy Addition			2007	431,389	39,217	11	39,217		254,912	24
25	Plumbing and Mechanical repairs capitalized for Medicaid			2007	20,861		3			20,861	25
26	Generator			2007	146,483	14,648	5	14,648		146,482	26
27	Mechanical/Electrical Systems Upgrade & Significant Bldg Improvements			2008	1,623,449	162,345	10	162,345		892,897	27
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrai										28
29	Dry Pendants			2008	3,020	302	10	302		1,661	29
30	Window Treatments			2008	30,741	3,074	5	3,074		30,741	30
31	Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2			2008	882,074	88,207	10	88,207		485,140	31
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/trac										32
33	Facility Sign			2008	12,836	1,284	10	1,284		7,060	33
34	Roof			2008	132,870	13,287	10	13,287		73,079	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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$	$ 4,975	37
38	Boiler Assessment (Asset #120 Addition)	2009	11,439	1,271	9	1,271		5,720	38
39	Satellite TV Equipment	2009	12,830	1,426	9	1,426		6,415	39
40	Garage Door	2009	662	74	9	74		331	40
41	Generator and Carrier Air Handler rpr Capitalized for Medicaid	2009	6,331		3			6,331	41
42	Boiler System Replacement	2010	73,440	9,180	8	9,180		32,130	42
43	A/C Unit (4)	2010	2,291	458	5	458		1,603	43
44	Concrete repairs to exits/stairwells-Capitalized for Medicaid	2010	13,900	2,316	3	2,316		13,900	44
45	Boiler System Repair Capitalized for Medicaid	2010	3,442	574	3	574		3,442	45
46	Sewage Pump	2011	1,219	174	7	174		435	46
47	Boiler/Heater/Call Light System rpr Capitalized for Medicaid	2011	13,367	4,456	3	4,456		11,140	47
48	Kwalu-Wall Covering/protection	2012	2,595	173	15	173		260	48
49	(3) PTAC Units	2012	1,865	373	5	373		559	49
50	Concrete Catch Basin	2012	3,110	207	15	207		311	50
51	Piping and Floor Drain	2012	935	38	25	38		55	51
52	Concrete Patio & Storm Drain	2012	46,184	3,079	15	3,079		4,618	52
53	FireSystemRpr&SmokeDetectorReplace-Capitalized for Medicaid	2012	5,753	1,918	3	1,918		2,877	53
54	SewerPipeCableing/DrainCleaning-Capitalized for Medicaid	2012	4,606	1,536	3	1,536		2,304	54
55	Cabling & Install Wireless Access Point	2013	3,219	80	20	80		80	55
56	Generator Service Capitalized for Medicaid	2013	4,359	727	3	727		727	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)		$ 7,419,121	$ 464,139		$ 464,139	$	$ 2,486,501	70

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 310,073	$ 40,980	$ 40,980	$	various	$ 179,796	71
72	Current Year Purchases	44,105	3,440	3,440		various	3,440	72
73	Fully Depreciated Assets	83,561	969	969		various	83,561	73
74								74
75	TOTALS	$ 437,739	$ 45,389	$ 45,389	$		$ 266,797	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)	$ 8,166,830	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 509,528	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 509,528	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)	$ 2,753,298	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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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 *

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.	/2014	$ N/A
13.	/2015	$ N/A
14.	/2016	$ 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: $ 34,705 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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 ____

*Response to No: Facility required employees to be certified prior to employment.

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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 Nsg & Rehab Center # 0046904 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 7,583	$	1
2	Cash-Patient Deposits	21,044		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	935,757		3
4	Supply Inventory (priced at cost)	5,249		4
5	Short-Term Investments			5
6	Prepaid Insurance	463		6
7	Other Prepaid Expenses	5,707		7
8	Accounts Receivable (owners or related parties)	(2,751,983)		8
9	Other(specify): Non resident A/R (see TB)	1,925		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,774,255)	$	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 Cos	59,050		15
16	Equipment, at Historical Cost	89,723		16
17	Accumulated Depreciation (book methods)	(24,843)		17
18	Deferred Charges	616		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)**	$ 125,677	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,648,578)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 142,044	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,264		28
29	Short-Term Notes Payable	82,418		29
30	Accrued Salaries Payable	224,413		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,105		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,656		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	7,035		36
37	Accrued Expenses	254,214		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 741,149	$	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)**	$ 741,149	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,389,727)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,648,578)	$	48

***(See instructions.)**

Facility Name & ID Number Granite Nsg & Rehab Center **#** 0046904 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,286,398)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,286,398)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(307,574)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,224,245	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(20,000)	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)**	$ 896,671	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,389,727)	24 *

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 3,720,075	1
2	Discounts and Allowances for all Levels	1,141,270	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,861,345	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	9,954	5
6	Therapy	493,187	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 503,141	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	1,940	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,548	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,768	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,256	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29,204	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,204	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	5,353	28
28a	Purchase Discounts & Misc Revenue	23,054	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,407	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,434,353	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	767,805	31
32	Health Care	2,664,143	32
33	General Administration	1,404,234	33
	B. Capital Expense		
34	Ownership	462,566	34
	C. Ancillary Expense		
35	Special Cost Centers	179,762	35
36	Provider Participation Fee	263,417	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,741,927	40
41	**Income before Income Taxes (line 30 minus line 40)****	(307,574)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (307,574)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,622,844	44
45	Private Pay - Net Inpatient Revenue	865,619	45
46	Medicare - Net Inpatient Revenue	2,205,951	46
47	Other-(specify) Hospice Contract	166,931	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,861,345	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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	1,912	2,080	$ 88,710	$ 42.65	1
2	Assistant Director of Nursing	1,880	2,064	58,029	28.11	2
3	Registered Nurses	5,222	5,683	149,714	26.34	3
4	Licensed Practical Nurses	23,098	25,465	548,432	21.54	4
5	CNAs & Orderlies	57,112	62,096	662,741	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,007	2,071	20,825	10.06	9
10	Activity Assistants	512	549	4,972	9.06	10
11	Social Service Workers	1,944	2,080	36,739	17.66	11
12	Dietician					12
13	Food Service Supervisor	1,160	1,616	25,989	16.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,804	4,275	37,057	8.67	15
16	Dishwashers	9,320	10,147	88,038	8.68	16
17	Maintenance Workers	2,199	2,199	38,158	17.35	17
18	Housekeepers	10,775	11,785	113,229	9.61	18
19	Laundry	2,541	2,711	24,486	9.03	19
20	Administrator	1,984	2,072	97,341	46.98	20
21	Assistant Administrator					21
22	Other Administrative	3,904	4,231	73,115	17.28	22
23	Office Manager	1,960	2,080	49,637	23.86	23
24	Clerical	1,885	2,101	25,632	12.20	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	1,674	1,866	24,737	13.26	31
32	Other Health Ca MDS Coordinator	3,806	4,299	102,269	23.79	32
33	Other(specify) Central Supply	1,980	2,196	30,045	13.68	33
34	TOTAL (lines 1 - 33)	140,679	153,666	$ 2,299,895 *	$ 14.97	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	648	9,600	9-3	36
37	Medical Records Consultant	49	3,045	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	1,543	11-3	44
45	Social Service Consultant	26	1,543	12-3	45
46	Other(specify)				46
47	Medical Admin Record Preparation	$5.50 per bed/mo	946	10-3	47
48					48
49	TOTAL (lines 35 - 48)	749	$ 35,253		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$ 0		50
51	Licensed Practical Nurses	N/A	0		51
52	Certified Nurse Assistants/Aides	N/A	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lewis Schweizer	Administrator	0	$ 97,341
Laura Barton	Bus. Office Mgr	0	49,637
Barbara J. Colp	AP/Payroll	0	25,632
Cherrell Gallion	Human Resources	0	36,372
Dawn Steward	Admiss. Coordinator	0	36,743
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 245,725

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 324,912
TOTAL (agree to Schedule V, line 17, col. 3)	$ 324,912
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,404
Freed, Maxick & Battaglia	Tax Fees	2,369
Various Legal Fees - See attached detailed listing		153,982
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 158,755

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,842
Unemployment Compensation Insurance	87,609
FICA Taxes	172,724
Employee Health Insurance	51,626
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Safety Rec. Program	1,754
Employee Benefits - Other	8,106
Employee Benefits - Short Term Disability	515
Employee Benefits-Hepatitis B Vaccine	24
TOTAL (agree to Schedule V, line 22, col.8)	$ 439,200

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	$ 1,990
Advertising: Employee Recruitment	2,371
Health Care Worker Background Check	6,296
(Indicate # of checks performed 234)	
Patient Background Checks 153	
Facility Advertising	13,759
IL Health Care Association Dues	4,747
Non-Allowable Dues & Subscriptions	(4,255)
Administrator/Business License/Notary	261
ChamberCommerce/INHAA Dues	1,020
Less: Public Relations Expense	( )
Non-allowable advertising	(13,759)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,430

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18,000
Seminar Expense	450
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,450

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 $1,337 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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **33,923** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedure 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. $ **179,235**
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 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 benefit 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 adjustec 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: 1/1/2013 Ending: 12/31/2013

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		6,410	5
6	Garage Door	2005	536	53	10	53		455	6
7	Ductwork Removal & Installation	2005	10,635	818	13	818		6,954	7
8	Replace Plumbing & Garbage Disposal	2005	6,767	520	13	520		4,424	8
9	Exhaust Fan - Laundry Area	2005	855	86	10	86		727	9
10	Doors (6)	2005	6,800	523	13	523		4,446	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		4,122	13
14	Fire Damper	2005	1,250	125	10	125		1,062	14
15	Pave Walkway	2005	5,714	357	8	357		5,714	15
16	Replace 140' Sewer & Floor	2005	39,530	3,041	13	3,041		25,847	16
17	Floor Replacement Cost @ 6/30/06	2006	17,434	1,320	10	1,320		9,898	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		19,792	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		11,563	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	$ 12,263		$ 12,263	$ 0	$ 110,781	34

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