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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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
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 01/01/15 to 12/31/15 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: 01/01/15 Ending: 12/31/15

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	13,758	5,097	8,168	27,023	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,758	5,097	8,168	27,023	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.09%

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 01/01/2005

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 4,151

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 12/31/15 Fiscal Year: 01/01 to 12/31/2015

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	159,621	24,988	14,094	198,703		198,703	(482)	198,221			1
2	Food Purchase		162,940		162,940		162,940	(665)	162,275			2
3	Housekeeping	133,257	17,231		150,488		150,488		150,488			3
4	Laundry	41,116	12,770		53,886		53,886	(482)	53,404			4
5	Heat and Other Utilities			94,844	94,844		94,844	(128)	94,716			5
6	Maintenance	35,687	35,035	57,986	128,708		128,708	(17,414)	111,294			6
7	Other (specify):* see trial balance			23,694	23,694		23,694		23,694			7
8	TOTAL General Services	369,681	252,964	190,618	813,263		813,263	(19,171)	794,092			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600	700	10,300			9
10	Nursing and Medical Records	1,601,069	138,637	119,381	1,859,087		1,859,087	(11,653)	1,847,434			10
10a	Therapy		2,925	721,045	723,970		723,970	(47,943)	676,027			10a
11	Activities	24,648	740	2,914	28,302		28,302		28,302			11
12	Social Services	54,873	26	1,723	56,622		56,622		56,622			12
13	CNA Training											13
14	Program Transportation			14,429	14,429		14,429		14,429			14
15	Other (specify):* see trial balance			12,269	12,269		12,269	(3,784)	8,485			15
16	TOTAL Health Care and Programs	1,680,590	142,328	881,361	2,704,279		2,704,279	(62,680)	2,641,599			16
	C. General Administration											
17	Administrative	260,946		318,684	579,630		579,630	(148,428)	431,202			17
18	Directors Fees											18
19	Professional Services			51,527	51,527		51,527	(2,318)	49,209			19
20	Dues, Fees, Subscriptions & Promotions			38,805	38,805		38,805	(21,818)	16,987			20
21	Clerical & General Office Expenses		45,133	27,987	73,120		73,120	(15,883)	57,237			21
22	Employee Benefits & Payroll Taxes			393,581	393,581		393,581	(320)	393,261			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,456	22,456		22,456	357	22,813			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,560	41,560		41,560	(2,928)	38,632			26
27	Other (specify):* see trial balance			110,794	110,794		110,794	(86,100)	24,694			27
28	TOTAL General Administration	260,946	45,133	1,005,394	1,311,473		1,311,473	(277,438)	1,034,035			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,311,217	440,425	2,077,373	4,829,015		4,829,015	(359,289)	4,469,726			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: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,253	20,253		20,253	459,916	480,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							135,367	135,367			32
33	Real Estate Taxes			97,697	97,697		97,697		97,697			33
34	Rent-Facility & Grounds			304,525	304,525		304,525	(279,914)	24,611			34
35	Rent-Equipment & Vehicles			54,913	54,913		54,913	1,487	56,400			35
36	Other (specify):* Off site storage			1,082	1,082		1,082		1,082			36
37	TOTAL Ownership			478,470	478,470		478,470	316,856	795,326			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			678	678		678		678			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			186,469	186,469		186,469		186,469			42
43	Other (specify):* see trial balance			251,445	251,445		251,445	(88,278)	163,167			43
44	TOTAL Special Cost Centers			438,592	438,592		438,592	(88,278)	350,314			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,311,217	440,425	2,994,435	5,746,077		5,746,077	(130,711)	5,615,366			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: 01/01/15 Ending: 12/31/15

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	(15,793)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(339)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(146)	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				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	(89,766)	27		24
25	Fund Raising, Advertising and Promotional	(16,485)	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	(63,120)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,062)		$	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)	55,351		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 55,351		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,711)		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: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Prof Dues	$ (4,497)	20	1
2	Remove Non-allowable Admissions Prof Dues	(800)	20	2
3	Remove Non-allowable Admin Books&Periodicles	(24)	21	3
4	Remove Non-allowable Admissions Other Supplies	(11,275)	21	4
5	Remove Non-allowable Insurance Costs	(2,928)	26	5
6	Remove Non-allow Outpatient Svcs-Consol Billing	(3)	43	6
7	Remove Non-allowable Dental Physician Fees	(95)	43	7
8	Remove Non-allowable HR EE Background checks	(36)	20	8
9	Remove Non-allowable BO Tax Preparation Fees	(2,432)	19	9
10	Remove Non-allow Admin-Purchased Services	(1,582)	27	10
11	Remove Non-allow Admin-Other Supplies&Mats	(1,662)	21	11
12	Remove Non-allowable Dietary Cleaning Supplies	(319)	1	12
13	Remove Non-allowable Dietary Other Supplies	(21)	1	13
14	Remove Non-allowable Dietary Raw Food	(519)	2	14
15	Remove Non-allowable Laundry - Laundry Soap	(482)	4	15
16	Remove Non-allowable Plant Ops Water& Sewer	(128)	5	16
17	Remove Non-allowable Dietary Repairs	(60)	6	17
18	Remove Non-allowable Laundry Incontinence Sply	(447)	10	18
19	Addtl Allow Medical Director Physician Fees	700	9	19
20	Addtl Allow Nrs Admin-Other Supplies	113	10	20
21	Addtl Allow Nrs Admin-Legal Svcs	114	19	21
22	Addtl Allow Admin Minor Non-Ned Equipment	659	21	22
23	Addtl Allow Admin Other Supplies & Material	252	21	23
24	Addtl Allow Admin Postage	11	21	24
25	Addtl Allow EE Benefit Short Term Disability	45	22	25
26	Addtl Allow EE Benefit Tuition Reimb	2,000	22	26
27	Addtl Allow EE Benefit Life Insurance	76	22	27
28	Addtl Allow Lodging & Meals	357	24	28
29	Depreciation/Amort LHI	5,657	30	29
30	Depreciation/Amort MME	913	30	30
31	Current Year Depreciation Audit Adjustments LHI	(57)	30	31
32	Addtl Allow Admin Purchased Services	13	27	32
33	Addtl Allow Admin - Data Processing	150	27	33
34	Addtl Allow Nrs. Admin Rental/Lease	1,487	35	34
35	Remove Non-allowable Support Surfaces	(93)	43	35
36	Remove Non-allowable Prior Year Costs	(1,972)	43	36
37	Remove Non-allowable IV Prescription Drugs	(14,951)	43	37
38	Offset Misc. Rev Med. Surg,Food Sup, Incontinent	(2,069)	10	38
39	Offset Misc. Revenue Non-Med. Equip	(84)	6	39
40	Offset Misc. Revenue Other	(4)	21	40
41	Offset Interco Sold Services Revenue	(5,435)	10	41
42	Offset Interco Sold Services Revenue	(2,613)	6	42
43	Offset Interco Sold Services Revenue	(142)	1	43
44	Offset Interco Sold Services Revenue	(849)	17	44
45	Offset Interco Sold Services Revenue	(1,500)	22	45
46	Capitalize repairs & Maintenance & Equipment	(6,218)	6	46
47	Capitalize repairs & Maintenance & Equipment	(3,931)	21	47
48	Capitalize repairs & Maintenance & Equipment	(8,439)	6	48
49	**Total**	(63,120)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(482)	0	0	0	0	0	0	0	0	0	0	(482)	1
2	Food Purchase	(665)	0	0	0	0	0	0	0	0	0	0	(665)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(482)	0	0	0	0	0	0	0	0	0	0	(482)	4
5	Heat and Other Utilities	(128)	0	0	0	0	0	0	0	0	0	0	(128)	5
6	Maintenance	(17,414)	0	0	0	0	0	0	0	0	0	0	(17,414)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,171)	0	0	0	0	0	0	0	0	0	0	(19,171)	8
	B. Health Care and Programs													
9	Medical Director	700	0	0	0	0	0	0	0	0	0	0	700	9
10	Nursing and Medical Records	(7,838)	(3,815)	0	0	0	0	0	0	0	0	0	(11,653)	10
10a	Therapy	(15,793)	(32,150)	0	0	0	0	0	0	0	0	0	(47,943)	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	(3,784)	0	0	0	0	0	0	0	0	0	(3,784)	15
16	**TOTAL Health Care and Programs**	(22,931)	(39,749)	0	0	0	0	0	0	0	0	0	(62,680)	16
	C. General Administration													
17	Administrative	(849)	(147,579)	0	0	0	0	0	0	0	0	0	(148,428)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,318)	0	0	0	0	0	0	0	0	0	0	(2,318)	19
20	Fees, Subscriptions & Promotions	(21,818)	0	0	0	0	0	0	0	0	0	0	(21,818)	20
21	Clerical & General Office Expenses	(16,313)	430	0	0	0	0	0	0	0	0	0	(15,883)	21
22	Employee Benefits & Payroll Taxes	621	(941)	0	0	0	0	0	0	0	0	0	(320)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	357	0	0	0	0	0	0	0	0	0	0	357	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,928)	0	0	0	0	0	0	0	0	0	0	(2,928)	26
27	Other (specify):*	(91,598)	0	5,498	0	0	0	0	0	0	0	0	(86,100)	27
28	**TOTAL General Administration**	(134,846)	(148,090)	5,498	0	0	0	0	0	0	0	0	(277,438)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(176,948)	(187,839)	5,498	0	0	0	0	0	0	0	0	(359,289)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	6,513	0	453,403	0	0	0	0	0	0	0	0	459,916	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	135,367	0	0	0	0	0	0	0	0	135,367	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(279,914)	0	0	0	0	0	0	0	0	(279,914)	34
35	Rent-Equipment & Vehicles	1,487	0	0	0	0	0	0	0	0	0	0	1,487	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,000	0	308,856	0	0	0	0	0	0	0	0	316,856	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):*	(17,114)	(71,164)	0	0	0	0	0	0	0	0	0	(88,278)	43
44	**TOTAL Special Cost Centers**	(17,114)	(71,164)	0	0	0	0	0	0	0	0	0	(88,278)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(186,062)	(259,003)	314,354	0	0	0	0	0	0	0	0	(130,711)	45

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grou	Orchard Park	Insurance
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Tara Pharmacy SE, LL	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	$ 318,684	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 171,105	$ (147,579)	1
2	V	15	Wireless Access Points License Fee	643	Raimax Healthcare Solutions Group, LLC	0.00%	204	(439)	2
3	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	255	(3,345)	3
4	V	10	Misc Sales &Delivery Charges	303	Tara Pharmacy SE, LLC	0.00%		(303)	4
5	V	10	Pharmacy Consulting Services	18,576	Tara Pharmacy SE, LLC	0.00%	15,064	(3,512)	5
6	V	43	Flu Vac/Prescription Drug- Residents	210,536	Tara Pharmacy SE, LLC	0.00%	139,372	(71,164)	6
7	V	22	Flu & Hep B Vaccine for Employees	1,464	Tara Pharmacy SE, LLC	0.00%	523	(941)	7
8	V	10a	Physical Therapy Fees	284,066	Tara Therapy, LLC	0.00%	297,665	13,599	8
9	V	10a	Occupational Therapy Fees	249,748	Tara Therapy, LLC	0.00%	214,914	(34,834)	9
10	V	10a	Speech Therapy Fees	186,440	Tara Therapy, LLC	0.00%	175,525	(10,915)	10
11	V	21	Telephone Cost Reduction Project		Raimax Healthcare Solutions Group, LLC	0.00%	430	430	11
12	V								12
13	V								13
14	Total			$ 1,274,060			$ 1,015,057	$ * (259,003)	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: 01/01/15 Ending: 12/31/15

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	$ 304,525	Colonnades Property Company, LLC	0.00%	$	$ (304,525)	15
16	V	30	Depreciation Leasehold Imp		Colonnades Property Company, LLC	0.00%	341,728	341,728	16
17	V	30	Depreciation Major Moveable		Colonnades Property Company, LLC	0.00%	22,693	22,693	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%	135,367	135,367	20
21	V	34	Mortgage Insurance Premium		Colonnades Property Company, LLC	0.00%	24,611	24,611	21
22	V								22
23	V								23
24	V	1	Dietary Services	288	Scenic Nursing and Rehabilitation Center, LLC	0.00%	288		24
25	V	27	Administrative Services	464	Scenic Nursing and Rehabilitation Center, LLC	0.00%	464		25
26	V	27	Admissions Services	874	Brandon Nursing and Rehabilitation Center, LLC	0.00%	874		26
27	V	10	LPN Services	141	White Hall Nursing and Rehabilitation Center, LLC	0.00%	141		27
28	V	6	Maintenance Services	326	White Hall Nursing and Rehabilitation Center, LLC	0.00%	326		28
29	V	15	Nursing Admin Services	1,642	White Hall Nursing and Rehabilitation Center, LLC	0.00%	1,642		29
30	V	1	Dietary Services	8,305	Stearns Nursing and Rehabilitation Center, LLC	0.00%	8,305		30
31	V	6	Maintenance Services	817	Stearns Nursing and Rehabilitation Center, LLC	0.00%	817		31
32	V	10	LPN Services	648	Stearns Nursing and Rehabilitation Center, LLC	0.00%	648		32
33	V	15	Nursing Admin Services	266	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	266		33
34	V	1	Dietary Services	311	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	311		34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 318,607			$ 632,961	$ * 314,354	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: 01/01/15 Ending: 12/31/15

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, LLC					1
2			Lake City Nursing and Rehabilitation Center, LLC					2
3			Mobile Nursing and Rehabilitation Center, LLC					3
4			Florence Nursing and Rehabilitation Center, LLC					4
5			Birmingham Nrs&Rehab Center East, LLC					5
6			Birmingham Nursing and Rehabilitation Center, LLC					6
7			Eight Mile Nursing and Rehabilitation Center, LLC					7
8			North Hill Nursing and Rehabilitation Center, LLC					8
9			Elba Nursing and Rehabilitation Center, LLC					9
10			Quince Nursing and Rehabilitation Center, LLC					10
11			Allenbrooke Nursing and Rehabilitation Center, LLC					11
12			Tupelo Nursing and Rehabilitation Center, LLC					12
13			Brandon Nursing and Rehabilitation Center, LLC					13
14			Lakeland Nursing and Rehabilitation Center, LLC					14
15			McComb Nursing and Rehabilitation Center, LLC					15
16			Cleveland Nursing and Rehabilitation Center, LLC					16
17			Chadwick Nursing and Rehabilitation Center, LLC					17
18			Manhattan Nursing and Rehabilitation Center, LLC					18
19			Ruleville Nursing and Rehabilitation Center, LLC					19
20			Farmerville Nursing and Rehabilitation Center, LLC					20
21			Bernice Nursing and Rehabilitation Center, LLC					21
22			Ruston Nursing and Rehabilitation Center, LLC					22
23			Natchitoches Nursing and Rehabilitation Center, LLC					23
24			Winnfield Nursing and Rehabilitation Center, LLC					24
25			Ringgold Nursing and Rehabilitation Center, LLC					25
26			Arcadia Nursing and Rehabilitation Center, LLC					26
27			Jena Nursing and Rehabilitation Center, LLC					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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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	4,217	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	4,217	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President	Admin of	0.00	***	0.57	1.43	VP of TC	3,740	17	7
8			Tara Cares								8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										9
10											10
11											11
12											12
13								TOTAL	$ 12,174		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: 01/01/15 Ending: 12/31/15

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	377,160,268	40	$ 341,807	$ 262,439	5,425,681	$ 4,916	1
2	5	Administrative Services Costs	Days	1,533,632	36	40,064	0	27,010	706	2
3	6	Administrative Services Costs	Days	1,533,632	36	85,860	0	27,010	1,510	3
4	10	Administrative Services Costs	Total Costs	377,160,268	40	2,765,952	2,197,104	5,425,681	39,780	4
5	17	Administrative Services Costs	Days	1,533,632	36	5,577,068	5,577,068	27,010	98,226	5
6	19	Administrative Services Costs	Days	1,533,632	36	10,399	0	27,010	183	6
7	20	Administrative Services Costs	Days	1,533,632	36	20,434	0	27,010	360	7
8	21	Administrative Services Costs	Days	1,533,632	36	248,288	0	27,010	4,373	8
9	22	Administrative Services Costs	Days	1,533,632	36	742,289	0	27,010	13,073	9
10	24	Administrative Services Costs	Days	1,533,632	36	139,206	0	27,010	2,452	10
11	26	Administrative Services Costs	Days	1,533,632	36	5,592	0	27,010	99	11
12	27	Administrative Services Costs	Days	1,533,632	36	104,557	0	27,010	1,841	12
13	30	Administrative Services Costs	Days	1,533,632	36	101,450	0	27,010	1,786	13
14	31	Administrative Services Costs	Days	1,533,632	36	13,775	0	27,010	243	14
15	33	Administrative Services Costs	Days	1,533,632	36	29,603	0	27,010	521	15
16	34	Administrative Services Costs	Days	1,533,632	36	57,221	0	27,010	1,008	16
17	35	Administrative Services Costs	Days	1,533,632	36	1,602	0	27,010	28	17
18										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 faciltiy. Therefore, Aurora Cares, LLC is not								21
22		considered a Home Office by CMS and as defined in 42CFR 421.404.								22
23										23
24										24
25	TOTALS					$ 10,285,167	$ 8,036,611		$ 171,105	25

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Land and Building	$19,274.00	6/20/12	$ 5,194,800	$ 4,878,370	07/01/2047	0.0275	$ 135,367	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related				$19,274.00		$ 5,194,800	$ 4,878,370			$ 135,367	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,194,800	$ 4,878,370			$ 135,367	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 24,611 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: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	97,580	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.)	$	95,277	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,303)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	100,000	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.	$	97,697	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	83,929	8
2011	86,519	9
2012	92,506	10
2013	92,882	11
2014	95,277	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 90,503.64	$ 90,503.64
2.	22-2-20-07-08-201-011	3500 Century Dr. Lot 2	$ 4,772.88	$ 4,772.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 95,276.52	$ 95,276.52

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,856 B. General Construction Type: Exterior Brick Frame Metal 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 [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: 92,983
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&OtherCostsIncurred2009&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: 01/01/15 Ending: 12/31/15

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	$	$ 400,419	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		19,152	13
14	Sprinkler System			2006	232,098	19,342	12	19,342		183,745	14
15	Emergency Lighting			2006	2,034	169	12	169		1,610	15
16	Weatherproof Lighting			2006	5,470	456	12	456		4,331	16
17	Exhaust Hood			2006	8,017	668	12	668		6,347	17
18	Sign			2006	800	80	10	80		760	18
19	Utility Room Cabinet			2006	2,946	246	12	246		2,333	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		1,219	21
22	Concrete Sidewalk			2007	2,470	247	10	247		2,100	22
23	Mag Locks and Key Pads			2007	2,604	260	10	260		2,213	23
24	Physical Therapy Addition			2007	431,389	39,217	11	39,217		333,346	24
25	Plumbing and Mechanical repairs capitalized for Medicaid			2007	20,861		3			20,861	25
26	Generator			2007	146,483		5			146,483	26
27	Mechanical/Electrical Systems Upgrade & Significant Bldg Improvements			2008	1,623,449	162,345	10	162,345		1,217,587	27
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails										28
29	Dry Pendants			2008	3,020	302	10	302		2,265	29
30	Window Treatments			2008	30,741		5			30,741	30
31	Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2			2008	882,074	88,207	10	88,207		661,555	31
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track										32
33	Facility Sign			2008	12,836	1,284	10	1,284		9,628	33
34	Roof			2008	132,870	13,287	10	13,287		99,653	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: 01/01/15 Ending: 12/31/15

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	$	$ 7,187	37
38	Boiler Assessment (Asset #120 Addition)	2009	11,439	1,271	9	1,271		8,262	38
39	Satellite TV Equipment	2009	12,830	1,426	9	1,426		9,266	39
40	Garage Door	2009	662	74	9	74		479	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		50,490	42
43	A/C Unit (4)	2010	2,291	229	5	229		2,291	43
44	Concrete repairs to exits/stairwells-Capitalized for Medicaid	2010	13,900		3			13,900	44
45	Boiler System Repair Capitalized for Medicaid	2010	3,442		3			3,442	45
46	Sewage Pump	2011	1,219	174	7	174		784	46
47	Boiler/Heater/Call Light System rpr Capitalized for Medicaid	2011	13,367		3			13,367	47
48	Kwalu-Wall Covering/protection	2012	2,595	173	15	173		606	48
49	(3) PTAC Units	2012	1,865	373	5	373		1,305	49
50	Concrete Catch Basin	2012	3,110	207	15	207		725	50
51	Piping and Floor Drain	2012	935	38	25	38		130	51
52	Concrete Patio & Storm Drain	2012	46,184	3,079	15	3,079		10,776	52
53	FireSystemRpr&SmokeDetectorReplace-Capitalized for Medicaid	2012	5,753	958	3	958		5,753	53
54	SewerPipeCableing/DrainCleaning-Capitalized for Medicaid	2012	4,606	767	3	767		4,606	54
55	Cabling & Install Wireless Access Point	2013	3,219	161	20	161		402	55
56	Generator Service Capitalized for Medicaid	2013	4,359	1,453	3	1,453		3,633	56
57	Facility Sign	2014	10,117	1,012	10	1,012		1,518	57
58	Seal Parking Lot and Repaint Lines	2014	3,700	1,850	2	1,850		2,775	58
59	Thermostatic Mixing Valve	2015	7,614	381	10	381		381	59
60	Roof Repair	2015	4,293	215	10	215		215	60
61	Generator Repair	2015	4,146	415	5	415		415	61
62									62
63	Note: See additional building improvements made by former		157,209	11,814		11,814		134,501	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)		$ 7,606,200	$ 453,607		$ 453,607	$	$ 3,506,335	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: 01/01/15 Ending: 12/31/15

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	$ 297,388	$ 34,743	$ 34,743	$	various	$ 193,371	71
72	Current Year Purchases	17,037	1,019	1,019		various	1,019	72
73	Fully Depreciated Assets	155,017	2,615	2,615		various	154,640	73
74								74
75	TOTALS	$ 469,442	$ 38,377	$ 38,377	$		$ 349,030	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	None			$	$	$	$		$	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)	$ 8,385,612	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 491,984	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 491,984	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)	$ 3,855,365	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	None	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	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: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 58,232 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: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 52,753	$	1
2	Cash-Patient Deposits	31,130		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,061,197		3
4	Supply Inventory (priced at cost)	7,793		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,251		6
7	Other Prepaid Expenses	12,081		7
8	Accounts Receivable (owners or related parties)	(283,471)		8
9	Other(specify): Non resident A/R (see TB)	10,313		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 893,047	$	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	76,781		15
16	Equipment, at Historical Cost	108,418		16
17	Accumulated Depreciation (book methods)	(65,712)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(419)		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)**	$ 120,268	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,013,315	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 250,578	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,634		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,600		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,483		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(9,129)		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	13,895		36
37	Accrued Expenses	145,959		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 692,020	$	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)**	$ 692,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 321,295	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,013,315	$	48

***(See instructions.)**

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 228,025	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 228,025	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,476)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	200,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(99,254)	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)**	$ 93,270	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)**	$ 321,295	24 *

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 4,143,060	1
2	Discounts and Allowances for all Levels	1,104,795	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,247,855	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	15,793	5
6	Therapy	458,650	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 474,443	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,954	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	437	19
20	Radiology and X-Ray	834	20
21	Other Medical Services	1,014	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,239	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,710	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,710	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	(7,681)	28
28a	Purchase Discounts & Misc Revenue	13,035	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,354	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,738,601	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	813,263	31
32	Health Care	2,704,279	32
33	General Administration	1,311,473	33
	B. Capital Expense		
34	Ownership	478,470	34
	C. Ancillary Expense		
35	Special Cost Centers	252,123	35
36	Provider Participation Fee	186,469	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,746,077	40
41	**Income before Income Taxes (line 30 minus line 40)****	(7,476)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (7,476)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,131,610	44
45	Private Pay - Net Inpatient Revenue	790,618	45
46	Medicare - Net Inpatient Revenue	2,161,980	46
47	Other-(specify) Hospice	163,647	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,247,855	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: 01/01/15 Ending: 12/31/15

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	1,531	1,601	$ 64,908	$ 40.54	1
2	Assistant Director of Nursing	1,400	1,702	64,521	37.91	2
3	Registered Nurses	6,883	7,256	210,406	29.00	3
4	Licensed Practical Nurses	21,625	23,514	515,119	21.91	4
5	CNAs & Orderlies	54,001	58,360	636,925	10.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,658	2,050	20,423	9.96	9
10	Activity Assistants	391	442	4,225	9.56	10
11	Social Service Workers	2,873	3,058	54,873	17.94	11
12	Dietician					12
13	Food Service Supervisor	1,808	2,155	37,072	17.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,080	4,543	42,734	9.41	15
16	Dishwashers	8,247	9,013	79,815	8.86	16
17	Maintenance Workers	2,144	2,309	35,687	15.46	17
18	Housekeepers	12,013	13,482	133,257	9.88	18
19	Laundry	3,893	4,135	41,116	9.94	19
20	Administrator	1,944	2,312	103,995	44.98	20
21	Assistant Administrator					21
22	Other Administrative	3,854	4,209	77,840	18.49	22
23	Office Manager	2,023	2,359	53,340	22.61	23
24	Clerical	1,769	1,987	25,771	12.97	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	1,932	2,152	38,002	17.66	31
32	Other Health C: MDS Coordinator	2,399	2,826	67,686	23.95	32
33	Other(specify) Central Supply	236	258	3,502	13.57	33
34	TOTAL (lines 1 - 33)	136,704	149,723	$ 2,311,217 *	$ 15.44	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	172	9,600	9-3	36
37	Medical Records Consultant	48	3,360	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18/bed/month	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	24	1,586	11-3	44
45	Social Service Consultant	24	1,586	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	268	$ 34,708		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	977	$ 70,346	10-3	50
51	Licensed Practical Nurses	186	6,901	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,163	$ 77,247		53

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Martin	Administrator	0	$ 43,701
Linda Shuh	Administrator	0	60,294
Kyle Baalman	Bus. Office Mgr	0	14,075
Laura Barton	Bus. Office Mgr	0	39,266
Dawn Steward	Admissions Director	0	40,693
Barbara J. Colp	Bus. Office Asst	0	25,771
Cherrell Gallion	Human Resources		37,146
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 260,946

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 318,684
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 318,684

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,462
Freed, Maxick & Battaglia	Tax Fees	2,432
Various Legal Fees - See attached detailed listing		46,633
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 51,527

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,443
Unemployment Compensation Insurance	107,693
FICA Taxes	177,262
Employee Health Insurance	302
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Safety Rec. Program	4,723
Employee Benefits - Other	18,340
Employee Benefits - Short Term Disability	313
Employee Benefits-Hepatitis B Vaccine	
Employee Benefit -Exchange / Tuition Reimb	3,497
Employee Benefit -Life Insurance (ER)	698
Employee Benefits - Dental Insurance (ER)	(10)
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,261

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	$ 1,824
Advertising: Employee Recruitment	8,601
Health Care Worker Background Check	297
(Indicate # of checks performed 43)	
Patient Background Checks 199	1,990
Facility Advertising	16,658
IL Health Care Association Dues/Chamber of	5,899
Non Allowable Il Healthcare dues/Chamber o	(5,297)
Citrix/Business License/Walmart/fingerprinti	2,700
Management & Networking Services/ COCM	800
Less: Public Relations Expense	( )
Non-allowable advertising	(16,485)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,987

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	22,396
Seminar Expense	417
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,813

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

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													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 $1,402 net of non-allowables**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,937** 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 for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **186,469**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes outpatient therapy** 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? **No** Indicate the amount. $ **N/A**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **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: 1/1/2015 Ending: 12/31/2015

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	377	10	377		7,542	5
6	Garage Door	2005	536	27	10	27		536	6
7	Ductwork Removal & Installation	2005	10,635	818	13	818		8,590	7
8	Replace Plumbing & Garbage Disposal	2005	6,767	520	13	520		5,465	8
9	Exhaust Fan - Laundry Area	2005	855	43	10	43		855	9
10	Doors (6)	2005	6,800	523	13	523		5,492	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	243	10	243		4,850	13
14	Fire Damper	2005	1,250	63	10	63		1,250	14
15	Pave Walkway	2005	5,714	0	8	0		5,714	15
16	Replace 140' Sewer & Floor	2005	39,530	3,041	13	3,041		31,928	16
17	Floor Replacement Cost @ 6/30/06	2006	17,434	1,979	10	1,979		13,197	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		25,070	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		14,646	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	$ 11,814		$ 11,814	$ 0	$ 134,501	34

See page 12A Line 63

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