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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: Valerie M Gaydosh **Telephone Number:** (716)972-2512
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 01/01/2017 to 12/31/2017 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) Valerie M Gaydosh

(Title) VP of Finance - Reimbursement for 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: 01/01/2017 Ending: 12/31/2017

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	14,793	5,531	9,071	29,395	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,793	5,531	9,071	29,395	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.64%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 01/01/2005 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 3,158

Medicare Intermediary Wisconsin Physicians Insurance Corp (WSP)

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 12/31/17 Fiscal Year: 1/1 to 12/31/17

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	201,029	31,562	17,941	250,532		250,532		250,532			1
2	Food Purchase		194,229		194,229		194,229	(139)	194,090			2
3	Housekeeping	143,436	20,661		164,097		164,097		164,097			3
4	Laundry	35,800	9,887	446	46,133		46,133		46,133			4
5	Heat and Other Utilities			109,279	109,279		109,279		109,279			5
6	Maintenance	49,371	26,336	77,616	153,323		153,323	(34,811)	118,512			6
7	Other (specify):* see trial balance			26,768	26,768		26,768		26,768			7
8	TOTAL General Services	429,636	282,675	232,050	944,361		944,361	(34,950)	909,411			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,575,441	148,096	297,153	2,020,690		2,020,690	(9,288)	2,011,402			10
10a	Therapy		4,773	726,070	730,843		730,843	6,184	737,027			10a
11	Activities	48,596	4,595	2,977	56,168		56,168		56,168			11
12	Social Services	44,612	198	1,587	46,397		46,397		46,397			12
13	CNA Training											13
14	Program Transportation			20,277	20,277		20,277	(2,873)	17,404			14
15	Other (specify):* see trial balance			10,702	10,702		10,702	(2,617)	8,085			15
16	TOTAL Health Care and Programs	1,668,649	157,662	1,076,766	2,903,077		2,903,077	(8,594)	2,894,483			16
	C. General Administration											
17	Administrative	226,816		299,232	526,048		526,048	(107,626)	418,422			17
18	Directors Fees											18
19	Professional Services			29,557	29,557		29,557	(2,505)	27,052			19
20	Dues, Fees, Subscriptions & Promotions			41,366	41,366		41,366	(22,263)	19,103			20
21	Clerical & General Office Expenses	14,798	45,954	79,939	140,691		140,691	(29,585)	111,106			21
22	Employee Benefits & Payroll Taxes			493,300	493,300		493,300	(363)	492,937			22
23	Inservice Training & Education											23
24	Travel and Seminar			35,673	35,673		35,673		35,673			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			129,936	129,936		129,936	(2,600)	127,336			26
27	Other (specify):* see trial balance			215,179	215,179		215,179	(177,412)	37,767			27
28	TOTAL General Administration	241,614	45,954	1,324,182	1,611,750		1,611,750	(342,354)	1,269,396			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,339,899	486,291	2,632,998	5,459,188		5,459,188	(385,898)	5,073,290			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: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			19,493	19,493		19,493	456,473	475,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							129,950	129,950			32
33	Real Estate Taxes			104,607	104,607		104,607		104,607			33
34	Rent-Facility & Grounds			302,833	302,833		302,833	(279,207)	23,626			34
35	Rent-Equipment & Vehicles			53,688	53,688		53,688		53,688			35
36	Other (specify):* **Off site Storage**			1,398	1,398		1,398		1,398			36
37	**TOTAL Ownership**			482,019	482,019		482,019	307,216	789,235			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			720	720		720		720			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,363	206,363		206,363		206,363			42
43	Other (specify):* **see trial balance**			251,226	251,226		251,226	(73,684)	177,542			43
44	**TOTAL Special Cost Centers**			458,309	458,309		458,309	(73,684)	384,625			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,339,899	486,291	3,573,326	6,399,516		6,399,516	(152,366)	6,247,150			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: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(139)	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	(17,680)	21		18
19	Entertainment				19
20	Contributions	(413)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(182,497)	27		24
25	Fund Raising, Advertising and Promotional	(17,663)	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	(75,576)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,968)		$	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)	141,602		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 141,602		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (152,366)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues& Subscriptions	$ (2,131)	20	1
2	Remove Non-allowable Admiss Dues& Subscriptions	(750)	20	2
3	Remove Non-allowable Finance Charges	(1,004)	21	3
4	Remove Non-allowable Admin Other Supplies	(58)	21	4
5	Remove Non-allowable Insurance Cost	(2,600)	26	5
6	Remove Non-allowable NRS Admin- Res Transport	(2,873)	14	6
7	Remove Non-allowable HR-EE Background Checks	(1,719)	20	7
8	Remove Non-allowable BO Tax Preperation Fees	(2,505)	19	8
9	Remove Non-allow Admin-TaxCreditSvcs(WOTC)	(2,403)	21	9
10	Remove Non-allowable Admissions Other Supplies	(8,154)	21	10
11	Remove Non-allowable Prior Year Costs	(2,520)	43	11
12	Remove Non-allowable IV Rx Drugs Cost	(5,482)	43	12
13	Offset Misc. Revenue Med Surg	(1,467)	10	13
14	Offset Misc. Revenue Food Supp	(92)	10	14
15	Offset Misc. Revenue Non-Med Equipment	(30)	6	15
16	Offset Misc. Revenue Incontinent Supplies	(702)	10	16
17	Offset Misc. Revenue Equipment	(61)	10	17
18	Offset Misc. Revenue Other	(8)	21	18
19	Offset Interco Sold Services Revenue	(185)	6	19
20	Offset Interco Sold Services Revenue	(343)	10	20
21	Offset Interco Sold Services Revenue	(398)	10	21
22	Offset Interco Sold Services Revenue	(67)	10	22
23	Offset Interco Sold Services Revenue	(161)	22	23
24	Offset Outpatient Physical Therapy Revenue	(9,817)	10a	24
25	Offset Outpatient Occupational Therapy Revenue	(837)	10a	25
26	Offset Outpatient Speech Therapy Revenue	(310)	10a	26
27	Capitalize Repairs & Maintenance & Equipment	(3,589)	10	27
28	Capitalize Repairs & Maintenance & Equipment	(5,676)	6	28
29	Capitalize Repairs & Maintenance & Equipment	(28,920)	6	29
30	Depreciation/Amort LHI	5,034	30	30
31	Depreciation/Amort MME	4,309	30	31
32	Current Year Depreciation Audit Adjustments LHI	(57)	30	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**	(75,576)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(139)	0	0	0	0	0	0	0	0	0	0	(139)	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(34,811)	0	0	0	0	0	0	0	0	0	0	(34,811)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(34,950)	0	0	0	0	0	0	0	0	0	0	(34,950)	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	(6,719)	(2,569)	0	0	0	0	0	0	0	0	0	(9,288)	10
10a	Therapy	(10,964)	17,148	0	0	0	0	0	0	0	0	0	6,184	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	(2,873)	0	0	0	0	0	0	0	0	0	0	(2,873)	14
15	Other (specify):*	0	(2,617)	0	0	0	0	0	0	0	0	0	(2,617)	15
16	**TOTAL Health Care and Programs**	(20,556)	11,962	0	0	0	0	0	0	0	0	0	(8,594)	16
	C. General Administration													
17	Administrative	0	(107,626)	0	0	0	0	0	0	0	0	0	(107,626)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,505)	0	0	0	0	0	0	0	0	0	0	(2,505)	19
20	Fees, Subscriptions & Promotions	(22,263)	0	0	0	0	0	0	0	0	0	0	(22,263)	20
21	Clerical & General Office Expenses	(29,307)	(278)	0	0	0	0	0	0	0	0	0	(29,585)	21
22	Employee Benefits & Payroll Taxes	(161)	(202)	0	0	0	0	0	0	0	0	0	(363)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(182,910)	0	5,498	0	0	0	0	0	0	0	0	(177,412)	27
28	**TOTAL General Administration**	(239,746)	(108,106)	5,498	0	0	0	0	0	0	0	0	(342,354)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(295,252)	(96,144)	5,498	0	0	0	0	0	0	0	0	(385,898)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	9,286	0	447,187	0	0	0	0	0	0	0	0	456,473	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	129,950	0	0	0	0	0	0	0	0	129,950	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(279,207)	0	0	0	0	0	0	0	0	(279,207)	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**	9,286	0	297,930	0	0	0	0	0	0	0	0	307,216	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):*	(8,002)	(65,682)	0	0	0	0	0	0	0	0	0	(73,684)	43
44	**TOTAL Special Cost Centers**	(8,002)	(65,682)	0	0	0	0	0	0	0	0	0	(73,684)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(293,968)	(161,826)	303,428	0	0	0	0	0	0	0	0	(152,366)	45

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Colonnades Property Co	Granite City	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, LI	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	$ 299,232	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 191,606	$ (107,626)	1
2	V	15	Wireless Access Points License Fee	620	Raimax Healthcare Solutions Group, LLC	0.00%	801	181	2
3	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	842	(2,758)	3
4	V	21	Carrier Comm Rev Offset		Raimax Healthcare Solutions Group, LLC	0.00%	(278)	(278)	4
5	V	10	Pharmacy Consulting Services	18,576	Tara Pharmacy SE, LLC	0.00%	16,007	(2,569)	5
6	V	43	Flu Vac/Prescription Drug- Residents	196,441	Tara Pharmacy SE, LLC	0.00%	130,759	(65,682)	6
7	V	22	Vaccines for Employees	2,664	Tara Pharmacy SE, LLC	0.00%	2,462	(202)	7
8	V	15	Misc Sales & Delivery Charges	40	Tara Pharmacy SE, LLC	0.00%		(40)	8
9	V	10a	Physical Therapy Fees	327,339	Tara Therapy, LLC	0.00%	347,545	20,206	9
10	V	10a	Occupational Therapy Fees	299,160	Tara Therapy, LLC	0.00%	296,906	(2,254)	10
11	V	10a	Speech Therapy Fees	99,331	Tara Therapy, LLC	0.00%	98,527	(804)	11
12	V								12
13	V								13
14	Total			$ 1,247,003			$ 1,085,177	$ * (161,826)	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: 01/01/2017 Ending: 12/31/2017

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	$ 302,833	Colonnades Property Company, LLC	0.00%	$	$ (302,833)	15
16	V	30	Depreciation Leasehold Imp		Colonnades Property Company, LLC	0.00%	339,150	339,150	16
17	V	30	Depreciation Major Moveable		Colonnades Property Company, LLC	0.00%	19,055	19,055	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%	129,950	129,950	20
21	V	34	Mortgage Insurance Premium		Colonnades Property Company, LLC	0.00%	23,626	23,626	21
22	V								22
23	V								23
24	V	1	Dietary Services	1,150	Allenbrooke Nursing and Rehabilitation Center, LLC	0.00%	1,150		24
25	V	1	Dietary Services	1,588	Scenic Nursing and Rehabilitation Center, LLC	0.00%	1,588		25
26	V	10	Nursing Services	6,176	Stearns Nursing and Rehabilitation Center, LLC	0.00%	6,176		26
27	V	21	Administrative Services	726	Stearns Nursing and Rehabilitation Center, LLC	0.00%	726		27
28	V	1	Dietary Services	4,494	Stearns Nursing and Rehabilitation Center, LLC	0.00%	4,494		28
29	V	10	Nursing Administrative Services	4,851	Stearns Nursing and Rehabilitation Center, LLC	0.00%	4,851		29
30	V	1	Dietary Services	1,047	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	1,047		30
31	V	10	RN Services	14,638	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	14,638		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 337,503			$ 640,931	$ * 303,428	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: 01/01/2017 Ending: 12/31/2017

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, L	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: 01/01/2017 Ending: 12/31/2017

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		$	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00			17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.61	1.53	Fin/ Adm. of TC	4,729	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CoCEO	Finance/ Admin	0.00	***	0.61	1.53	Fin/ Adm. of TC	4,729	17	5
6		for Tara Cares	of Tara Cares								6
7	Suzette Wilson	Vice President	Admin	0.00	***	0.61	1.53	VP of TC	3,528	17	7
8			of 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	$ 12,986		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: 01/01/2017 Ending: 2/31/2017

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	397,076,188	40	$ 361,293	$ 271,492	6,100,277	$ 5,553	1
2	5	Administrative Services Costs	Days	1,563,981	36	32,810	0	29,385	617	2
3	6	Administrative Services Costs	Days	1,563,981	36	78,542	0	29,385	1,476	3
4	10	Administrative Services Costs	Total Costs	397,076,188	40	2,599,967	2,057,996	6,100,277	39,943	4
5	17	Administrative Services Costs	Days	1,563,981	36	6,015,391	6,015,391	29,385	113,025	5
6	19	Administrative Services Costs	Days	1,563,981	36	10,151	0	29,385	190	6
7	20	Administrative Services Costs	Days	1,563,981	36	15,895	0	29,385	299	7
8	21	Administrative Services Costs	Days	1,563,981	36	304,103	0	29,385	5,711	8
9	22	Administrative Services Costs	Days	1,563,981	36	931,149	0	29,385	17,495	9
10	24	Administrative Services Costs	Days	1,563,981	36	106,199	0	29,385	1,996	10
11	26	Administrative Services Costs	Days	1,563,981	36	4,964	0	29,385	93	11
12	27	Administrative Services Costs	Days	1,563,981	36	86,350	0	29,385	1,623	12
13	30	Administrative Services Costs	Days	1,563,981	36	77,822	0	29,385	1,462	13
14	31	Administrative Services Costs	Days	1,563,981	36	10,367	0	29,385	195	14
15	33	Administrative Services Costs	Days	1,563,981	36	31,446	0	29,385	591	15
16	34	Administrative Services Costs	Days	1,563,981	36	69,368	0	29,385	1,303	16
17	35	Administrative Services Costs	Days	1,563,981	36	1,792	0	29,385	34	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					$ 10,737,609	$ 8,344,879		$ 191,606	25

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lancaster Pollard Mortgage Company	X		Land and Building	$19,274.50	6/20/12	$ 5,194,800	$ 4,678,885	07/01/2047	0.0275	$ 129,950	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$19,274.50		$ 5,194,800	$ 4,678,885			$ 129,950	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	$ 4,678,885			$ 129,950	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 23,626 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:** 01/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 106,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 103,007	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,493)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 108,100	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.		$ 104,607	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	92,506	8
	2013	92,882	9
	2014	95,277	10
	2015	103,384	11
	2016	103,007	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2016 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 Valerie M Gaydosh

TELEPHONE (716) 662-4955, ext. 512 FAX #: (716) 662-2529

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 97,846.72	$ 97,846.72
2.	22-2-20-07-08-201-011	3500 Century Dr. Lot 2	$ 5,160.12	$ 5,160.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 103,006.84	$ 103,006.84

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,956 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 [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).

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: 63,995
2. Number of Years Over Which it is Being Amortized: 5 years (60 Months)
3. Current Period Amortization: Included in Schedule VII B Ln 1, Col 7
4. Dates Incurred: Various and on the books of related entities

Nature of Costs: Inc. CapitalizedPre-openingSalaries,Benefits&OtherCostsIncurred. 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: 01/01/2017 Ending: 12/31/2017

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		$ 88,982	$	$ 578,383	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		10			20,160	13
14	Sprinkler System			2006	232,098	19,342	12	19,342		222,427	14
15	Emergency Lighting			2006	2,034	169	12	169		1,948	15
16	Weatherproof Lighting			2006	5,470	456	12	456		5,242	16
17	Exhaust Hood			2006	8,017	668	12	668		7,683	17
18	Sign			2006	800		10			800	18
19	Utility Room Cabinet			2006	2,946	245	12	245		2,823	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		1,506	21
22	Concrete Sidewalk			2007	2,470	124	10	124		2,470	22
23	Mag Locks and Key Pads			2007	2,604	130	10	130		2,604	23
24	Physical Therapy Addition			2007	431,389	39,217	11	39,217		411,780	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		1,542,277	27
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails										28
29	Dry Pendants			2008	3,020	302	10	302		2,869	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		837,969	31
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track										32
33	Facility Sign			2008	12,836	1,284	10	1,284		12,194	33
34	Roof			2008	132,870	13,287	10	13,287		126,227	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: 01/01/2017 Ending: 12/31/2017

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	$	$ 9,398	37
38	Boiler Assessment (Asset #120 Addition)	2009	11,439	1,271	9	1,271		10,804	38
39	Satellite TV Equipment	2009	12,830	1,426	9	1,426		12,117	39
40	Garage Door	2009	662	74	9	74		626	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		68,850	42
43	A/C Unit (4)	2010	2,291		5			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		1,132	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		952	48
49	(3) PTAC Units	2012	1,865	186	5	186		1,864	49
50	Concrete Catch Basin	2012	3,110	207	15	207		1,140	50
51	Piping and Floor Drain	2012	935	38	25	38		205	51
52	Concrete Patio & Storm Drain	2012	46,184	3,079	15	3,079		16,934	52
53	FireSystemRpr&SmokeDetectorReplace-Capitalized for Medicaid	2012	5,753		3			5,753	53
54	SewerPipeCableing/DrainCleaning-Capitalized for Medicaid	2012	4,606		3			4,606	54
55	Cabling & Install Wireless Access Point	2013	3,219	161	20	161		724	55
56	Generator Service Capitalized for Medicaid	2013	4,359		3			4,359	56
57	Facility Sign	2014	10,117	1,012	10	1,012		3,541	57
58	Seal Parking Lot and Repaint Lines Capitalized for Medicaid	2014	3,700		2			3,700	58
59	Thermostatic Mixing Valve	2015	7,614	761	10	761		1,903	59
60	Roof Repair - Capitalized for Medicaid	2015	4,293	429	10	429		1,073	60
61	Generator Repair - Capitalized for Medicaid	2015	4,146	829	5	829		2,073	61
62	Maglocks for 2 Doors - Capitalized for Medicaid	2016	4,217	422	10	422		633	62
63	Labor and Materials to attempt repair/replace fire panel - Capital	2016	5,260	351	15	351		526	63
64	20 Ton Rooftop A/C unit	2016	19,578	1,958	10	1,958		2,937	64
65	Water softener scale control media - Capital for Medicaid	2017	4,283	428	5	428		428	65
66	Paint-AllHallways, ActivityRoom,&DiningRoom-Cap for MCD	2017	8,932	893	5	893		893	66
67	Dish Room -FRP walls, Quarry tile floor w/ moisture membrane	2017	22,466	449	25	449		449	67
68	Paint-Dietary Office,DiningRoom,Kitchen&SupplyRoom Cap for	2017	12,258	1,226	5	1,226		1,226	68
69	Sewer - sump pump cleaning,sewer lift repair - Capitalized for M	2017	9,123	456	10	456		456	69
70	TOTAL (lines 4 thru 69)		$ 7,535,108	$ 441,190		$ 441,190	$	$ 4,252,527	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: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,535,108	$ 441,190		$ 441,190	$	$ 4,252,527	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10	Note: See additional building improvements made by former		157,209	9,083		9,083		153,027	10
11	property owner Healthcare REIT, Inc. on supplemental								11
12	schedule included as page 23 of the cost report.								12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,692,317	$ 450,273		$ 450,273	$	$ 4,405,554	34

**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: 01/01/2017 Ending: 12/31/2017

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	$ 288,277	$ 32,906	$ 32,906	$	various	$ 219,020	71
72	Current Year Purchases	3,589	598	598		various	598	72
73	Fully Depreciated Assets	200,392	1,272	1,272		various	200,392	73
74						various		74
75	TOTALS	$ 492,258	$ 34,776	$ 34,776	$		$ 420,010	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)	$ 8,494,545	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 485,049	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 485,049	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)	$ 4,825,564	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: 01/01/2017 Ending: 12/31/2017

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

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.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 67,699 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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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.

STATE OF ILLINOIS

Facility Name & ID Number Granite Nsg & Rehab Center **#** 0046904 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 232,761	$	1
2	Cash-Patient Deposits	12,530		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	758,082		3
4	Supply Inventory (priced at cost)	7,260		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,125		6
7	Other Prepaid Expenses	4,657		7
8	Accounts Receivable (owners or related parties)	(307,577)		8
9	Other(specify): Non Resident A/R (see TB)	5,163		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 716,001	$	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	118,825		15
16	Equipment, at Historical Cost	108,418		16
17	Accumulated Depreciation (book methods)	(104,603)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(1,911)		21
22	Other Long-Term Assets (spe Deposits Long Term	1,557		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 122,286	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 838,287	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 191,321	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,416		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	200,530		30
31	Accrued Taxes Payable (excluding real estate taxes)	47,770		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(9,238)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	11,568		36
37	Accrued Expenses	313,237		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 761,604	$	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)**	$ 761,604	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 76,683	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 838,287	$	48

***(See instructions.)**

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 792,513	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 792,513	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(586,831)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(128,999)	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)**	$ (715,830)	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)**	$ 76,683	24 *

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 4,732,922	1
2	Discounts and Allowances for all Levels	740,232	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,473,154	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	10,964	5
6	Therapy	358,295	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 369,259	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	3,707	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,967	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,687	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	-	(48,936)	28
28a	**Purchase Discounts & Misc Revenue**	3,514	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (45,422)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,812,685	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	944,361	31
32	Health Care	2,903,077	32
33	General Administration	1,611,750	33
	B. Capital Expense		
34	Ownership	482,019	34
	C. Ancillary Expense		
35	Special Cost Centers	251,946	35
36	Provider Participation Fee	206,363	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,399,516	40
41	**Income before Income Taxes (line 30 minus line 40)****	(586,831)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (586,831)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,701,932	44
45	Private Pay - Net Inpatient Revenue	739,956	45
46	Medicare - Net Inpatient Revenue	1,571,179	46
47	Other-(specify) **Hospice**	149,992	47
48	Other-(specify) **Medicare HMO**	310,095	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,473,154	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** see Pg 19 note **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: 01/01/2017 Ending: 12/31/2017

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	1,328	1,557	$ 60,315	$ 38.74	1
2	Assistant Director of Nursing			(2,127)		2
3	Registered Nurses	5,630	5,921	168,122	28.39	3
4	Licensed Practical Nurses	25,592	27,279	669,955	24.56	4
5	CNAs & Orderlies	48,165	51,846	624,457	12.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,068	2,208	31,929	14.46	9
10	Activity Assistants	1,396	1,498	16,667	11.13	10
11	Social Service Workers	2,570	2,721	44,612	16.40	11
12	Dietician					12
13	Food Service Supervisor	2,138	2,546	48,770	19.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,257	5,836	62,406	10.69	15
16	Dishwashers	9,240	9,910	89,853	9.07	16
17	Maintenance Workers	2,664	2,823	49,371	17.49	17
18	Housekeepers	13,546	14,761	143,436	9.72	18
19	Laundry	2,737	2,989	35,800	11.98	19
20	Administrator	1,598	1,836	73,109	39.82	20
21	Assistant Administrator	432	474	14,798	31.22	21
22	Other Administrative	5,018	5,762	81,251	14.10	22
23	Office Manager	1,851	2,088	48,374	23.17	23
24	Clerical	1,744	1,772	24,082	13.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,624	1,789	34,318	19.18	31
32	Other Health Care(specify)					32
33	Other(specify) Central Supply	1,356	1,471	20,401	13.87	33
34	TOTAL (lines 1 - 33)	135,954	147,087	$ 2,339,899 *	$ 15.91	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	104	$ 5,441	1-3	35
36	Medical Director	72	18,000	9-3	36
37	Medical Records Consultant	48	3,355	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	208	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	1,587	11-3	44
45	Social Service Consultant	24	1,587	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	480	$ 48,547		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	478	$ 25,420	10-3	50
51	Licensed Practical Nurses	1,268	47,542	10-3	51
52	Certified Nurse Assistants/Aides	7,269	176,595	10-3	52
53	TOTAL (lines 50 - 52)	9,015	$ 249,557		53

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christopher Cox	Administrator	0	$ 55,973
Michelle Plumb	Administrator	0	17,136
Barbara J. Colp	Bus. Office Mgr	0	31,871
Robin Wilkins	Bus. Office Mgr	0	16,503
Dawn Steward	Admissions Director	0	43,840
B.Colp,S.Cunningham. J.Johnson	Bus. Office Asst	0	24,082
C.Gallion, M.Bundy, S.Cunningham	Human Resources	0	37,411
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 226,816

B. Administrative - Other

Description	Amount
Tara Cares Administrative Service Fee	$ 299,232
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 299,232

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,533
Freed, Maxick & Battaglia	Tax Fees	2,505
Various Legal Fees - See attached detailed listing		24,519
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 29,557

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,042
Unemployment Compensation Insurance	104,857
FICA Taxes	178,538
Employee Health Insurance	131,410
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Safety Rec. Program	1,218
Employee Benefits - Other	18,227
Employee Benefits - Short Term Disability	188
Employee Benefits-Hepatitis B Vaccine	26
Employee Benefit -H.S.A. ER / Tuition Reimb	2,440
Employee Benefit -Life Insurance (ER)	690
Employee Benefits - Dental Insurance (ER)	1,301
TOTAL (agree to Schedule V, line 22, col.8)	$ 492,937

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

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

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	7,343
Health Care Worker Background Check	398
(Indicate # of checks performed 24)	
Patient Background Checks 181	1,881
Facility Advertising	17,663
IL Health Care Association Dues/Chamber of	5,903
Non Allowable Il Healthcare dues/Chamber o	(2,131)
Citrix/Business License/CDW Direct/Sams Cl	3,241
Fingerprinting	478
Less: Public Relations Expense	( )
Non-allowable advertising	(17,663)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,103

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	33,773
Seminar Expense	1,900
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35,673

**See instructions.

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 $3,772 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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,418** 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. $ **206,363**
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 services** 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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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 Nsg & Rehab Center # 0046904 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Made by Healthcare REIT (covered by rent at outset										9
10	of Change of Ownership)										10
11											11
12	Aspire Telephone System			2005	7,542		10			7,542	12
13	Garage Door			2005	536		10			536	13
14	Ductwork Removal & Installation			2005	10,635	818	13	818		10,226	14
15	Replace Plumbing & Garbage Disposal			2005	6,767	520	13	520		6,506	15
16	Exhaust Fan - Laundry Area			2005	855		10			855	16
17	Doors (6)			2005	6,800	523	13	523		6,538	17
18	Air Conditioning Units (3)			2005	3,294		5			3,294	18
19	Carpeting			2005	587		5			587	19
20	Roof Repairs - New Gutters and Facia			2005	4,850		10			4,850	20
21	Fire Damper			2005	1,250		10			1,250	21
22	Pave Walkway			2005	5,714		8			5,714	22
23	Replace 140' Sewer & Floor			2005	39,530	3,041	13	3,041		38,010	23
24	Floor Replacement Cost @ 6/30/06			2006	17,434		10			17,434	24
25	Floor Replacement Addl Cost Post 6/30/06			2006	(4,237)					(4,237)	25
26	Walk-in Cooler / Freezer			2006	31,667	2,639	12	2,639		30,408	26
27	Paint Exterior of Facility			2006	3,847		5			3,847	27
28	Plumbing Install Sinks (2)			2006	18,500	1,542	12	1,542		18,028	28
29	Carpeting			2006	1,639		5			1,639	29
30											30
31											31
32											32
33											33
34											34
35											35
36					157,209	9,083		9,083		153,027	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

XVII. INCOME STATEMENT Page 19 Note

Line 41 Income before Income Taxes (586,831) **
Does this agree with taxable income(loss) per Federal Income Tax Return?

** The Tax Return has been extended with a due date after the cost report filing date. It is expected that the cost report income and tax return income will agree.