FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0046904

Facility Name: Granite Nursing and Rehabilitation Center, LLC

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 01/01/2018 to 12/31/2018 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 Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	20,035	3,717	5,658	29,410	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,035	3,717	5,658	29,410	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.69%

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 3,637

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 12/31/18 Fiscal Year: 1/1 to 12/31/18

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, L # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	248,252	20,239	29,765	298,256		298,256		298,256			1
2	Food Purchase		209,327		209,327		209,327	(187)	209,140			2
3	Housekeeping	158,096	33,914		192,010		192,010		192,010			3
4	Laundry	57,355	13,309	268	70,932		70,932		70,932			4
5	Heat and Other Utilities			105,146	105,146		105,146		105,146			5
6	Maintenance	54,384	29,255	55,631	139,270		139,270	(19,039)	120,231			6
7	Other (specify):* see trial balance			30,049	30,049		30,049		30,049			7
8	**TOTAL General Services**	518,087	306,044	220,859	1,044,990		1,044,990	(19,226)	1,025,764			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,954,750	156,723	98,909	2,210,382		2,210,382	(8,791)	2,201,591			10
10a	Therapy		2,909	765,521	768,430		768,430	(2,565)	765,865			10a
11	Activities	50,136	1,778	3,350	55,264		55,264		55,264			11
12	Social Services	51,066		2,390	53,456		53,456		53,456			12
13	CNA Training											13
14	Program Transportation			18,077	18,077		18,077	(2,188)	15,889			14
15	Other (specify):* see trial balance			12,018	12,018		12,018	(3,356)	8,662			15
16	**TOTAL Health Care and Programs**	2,055,952	161,410	918,265	3,135,627		3,135,627	(16,900)	3,118,727			16
	C. General Administration											
17	Administrative	243,792		201,084	444,876		444,876	(6,787)	438,089			17
18	Directors Fees											18
19	Professional Services			71,711	71,711		71,711	(3,504)	68,207			19
20	Dues, Fees, Subscriptions & Promotions			38,201	38,201		38,201	(22,379)	15,822			20
21	Clerical & General Office Expenses	21,558	32,899	101,549	156,006		156,006	(48,502)	107,504			21
22	Employee Benefits & Payroll Taxes			483,416	483,416		483,416	32	483,448			22
23	Inservice Training & Education											23
24	Travel and Seminar			33,024	33,024		33,024		33,024			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			(16,163)	(16,163)		(16,163)	(2,600)	(18,763)			26
27	Other (specify):* see trial balance			53,043	53,043		53,043	(38,968)	14,075			27
28	**TOTAL General Administration**	265,350	32,899	965,865	1,264,114		1,264,114	(122,708)	1,141,406			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,839,389	500,353	2,104,989	5,444,731		5,444,731	(158,834)	5,285,897			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC #0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			17,927	17,927		17,927	282,167	300,094			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							127,128	127,128			32
33	Real Estate Taxes			98,995	98,995		98,995		98,995			33
34	Rent-Facility & Grounds			311,177	311,177		311,177	(288,065)	23,112			34
35	Rent-Equipment & Vehicles			60,795	60,795		60,795		60,795			35
36	Other (specify):* Off site Storage			1,549	1,549		1,549		1,549			36
37	**TOTAL Ownership**			490,443	490,443		490,443	121,230	611,673			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			588	588		588		588			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			204,244	204,244		204,244		204,244			42
43	Other (specify):* see trial balance			317,905	317,905		317,905	(45,775)	272,130			43
44	**TOTAL Special Cost Centers**			522,737	522,737		522,737	(45,775)	476,962			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,839,389	500,353	3,118,169	6,457,911		6,457,911	(83,379)	6,374,532			45

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(63)	2		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	(124)	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	(38,031)	21		18
19	Entertainment				19
20	Contributions	(640)	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	(43,826)	27		24
25	Fund Raising, Advertising and Promotional	(18,416)	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	(58,324)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,424)		$	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)	76,045		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 76,045		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (83,379)		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

STATE OF ILLINOIS

Granite Nursing and Rehabilitation Center, LLC

ID# 0046904

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues& Subscriptions	$ (2,757)	20	1
2	Remove Non-allowable Activities Dues& Subscriptions	(53)	20	2
3	Remove Non-allowable Finance Charges	(752)	21	3
4	Remove Non-allowable Admin Legal Fees	(221)	19	4
5	Remove Non-allowable Insurance Cost	(2,600)	26	5
6	Remove Non-allowable NRS Admin- Res Transport	(2,188)	14	6
7	Remove Non-allowable HR-EE Background Checks	(1,153)	20	7
8	Remove Non-allowable BO Tax Preperation Fees	(3,283)	19	8
9	Remove Non-allow Admin-TaxCreditSvcs(WOTC)	(1,443)	21	9
10	Remove Non-allowable Admissions Other Supplies	(6,551)	21	10
11	Remove Non-allowable Prior Year Costs	(19,328)	43	11
12	Remove Non-allowable IV Rx Drugs Cost	(543)	43	12
13	Offset Misc. Revenue Med Surg	(1,693)	10	13
14	Offset Misc. Revenue Food Supp	(115)	10	14
15	Offset Misc. Revenue Non-Med Equipment	(89)	6	15
16	Offset Misc. Revenue Incontinent Supplies	(667)	10	16
17	Offset Misc. Revenue Equipment	(10)	10	17
18	Offset Misc. Revenue Other	(4)	21	18
19	Offset Interco Sold Services Revenue	(49)	17	19
20	Offset Interco Sold Services Revenue	(10)	22	20
21	Offset Outpatient Physical Therapy Revenue	(6,453)	10a	21
22	Offset Outpatient Occupational Therapy Revenue	(819)	10a	22
23	Capitalize Repairs & Maintenance & Equipment	(2,924)	10	23
24	Capitalize Repairs & Maintenance & Equipment	(6,754)	6	24
25	Capitalize Repairs & Maintenance & Equipment	(3,296)	6	25
26	Capitalize Repairs & Maintenance & Equipment	(8,900)	6	26
27	Depreciation/Amort LHI	8,660	30	27
28	Depreciation/Amort MME	5,732	30	28
29	Current Year Depreciation Audit Adjustments LHI	(57)	30	29
30	Remove Non-allow Admin-Credit Card Activation Fee	(4)	21	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(58,324)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(187)	0	0	0	0	0	0	0	0	0	0	(187)	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	(19,039)	0	0	0	0	0	0	0	0	0	0	(19,039)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,226)	0	0	0	0	0	0	0	0	0	0	(19,226)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(5,409)	(3,382)	0	0	0	0	0	0	0	0	0	(8,791)	10
10a	Therapy	(7,272)	4,707	0	0	0	0	0	0	0	0	0	(2,565)	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	(2,188)	0	0	0	0	0	0	0	0	0	0	(2,188)	14
15	Other (specify):*	0	(3,356)	0	0	0	0	0	0	0	0	0	(3,356)	15
16	**TOTAL Health Care and Programs**	(14,869)	(2,031)	0	0	0	0	0	0	0	0	0	(16,900)	16
	C. General Administration													
17	Administrative	(49)	(6,738)	0	0	0	0	0	0	0	0	0	(6,787)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,504)	0	0	0	0	0	0	0	0	0	0	(3,504)	19
20	Fees, Subscriptions & Promotions	(22,379)	0	0	0	0	0	0	0	0	0	0	(22,379)	20
21	Clerical & General Office Expenses	(46,785)	(1,717)	0	0	0	0	0	0	0	0	0	(48,502)	21
22	Employee Benefits & Payroll Taxes	(10)	42	0	0	0	0	0	0	0	0	0	32	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):*	(44,466)	0	5,498	0	0	0	0	0	0	0	0	(38,968)	27
28	**TOTAL General Administration**	(119,793)	(8,413)	5,498	0	0	0	0	0	0	0	0	(122,708)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(153,888)	(10,444)	5,498	0	0	0	0	0	0	0	0	(158,834)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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	14,335	0	267,832	0	0	0	0	0	0	0	0	282,167	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	127,128	0	0	0	0	0	0	0	0	127,128	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(288,065)	0	0	0	0	0	0	0	0	(288,065)	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**	14,335	0	106,895	0	0	0	0	0	0	0	0	121,230	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):*	(19,871)	(25,904)	0	0	0	0	0	0	0	0	0	(45,775)	43
44	**TOTAL Special Cost Centers**	(19,871)	(25,904)	0	0	0	0	0	0	0	0	0	(45,775)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,424)	(36,348)	112,393	0	0	0	0	0	0	0	0	(83,379)	45

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 201,084	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 194,346	$ (6,738)	1
2	V	15	Wireless Access Points License Fee	513	RAImax Healthcare Solutions Group, LLC	0.00%	343	(170)	2
3	V	15	Patient Care Software	3,600	RAImax Healthcare Solutions Group, LLC	0.00%	414	(3,186)	3
4	V	21	Carrier Comm Rev Offset		RAImax Healthcare Solutions Group, LLC	0.00%	(1,717)	(1,717)	4
5	V	10	Pharmacy Consulting Services	18,576	Tara Pharmacy SE, LLC	0.00%	15,194	(3,382)	5
6	V	43	Flu Vac/Prescription Drug- Residents	281,095	Tara Pharmacy SE, LLC	0.00%	255,191	(25,904)	6
7	V	22	Vaccines for Employees	2,315	Tara Pharmacy SE, LLC	0.00%	2,357	42	7
8	V	10a	Physical Therapy Fees	315,793	Tara Therapy, LLC	0.00%	319,123	3,330	8
9	V	10a	Occupational Therapy Fees	332,639	Tara Therapy, LLC	0.00%	322,805	(9,834)	9
10	V	10a	Speech Therapy Fees	116,415	Tara Therapy, LLC	0.00%	127,626	11,211	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,272,030			$ 1,235,682	$ * (36,348)	14

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 311,177	Colonnades Property Company, LLC	0.00%	$	$ (311,177)	15
16	V	30	Depreciation Leasehold Imp		Colonnades Property Company, LLC	0.00%	169,448	169,448	16
17	V	30	Depreciation Major Moveable		Colonnades Property Company, LLC	0.00%	9,402	9,402	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%	127,128	127,128	20
21	V	34	Mortgage Insurance Premium		Colonnades Property Company, LLC	0.00%	23,112	23,112	21
22	V	10	Nursing Services	460	Stearns Nursing and Rehabilitation, LLC	0.00%	460		22
23	V	1	Dietary Services	25,909	Stearns Nursing and Rehabilitation, LLC	0.00%	25,909		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 337,546			$ 449,939	$ * 112,393	39

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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, I	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, LL	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 Nursing and Rehabilitation Center, # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	4,848	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	4,848	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	3,683	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	$ 13,379		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	410,302,287	40	$ 363,526	$ 281,911	6,245,467	$ 5,535	1
2	5	Administrative Services Costs	Days	1,573,455	36	31,735	0	29,401	594	2
3	6	Administrative Services Costs	Days	1,573,455	36	103,375	0	29,401	1,933	3
4	10	Administrative Services Costs	Total Costs	410,302,287	40	2,503,148	1,991,472	6,245,467	38,108	4
5	17	Administrative Services Costs	Days	1,573,455	36	6,190,204	6,190,204	29,401	115,665	5
6	19	Administrative Services Costs	Days	1,573,455	36	18,129	0	29,401	339	6
7	20	Administrative Services Costs	Days	1,573,455	36	59,441	0	29,401	1,110	7
8	21	Administrative Services Costs	Days	1,573,455	36	397,184	0	29,401	7,422	8
9	22	Administrative Services Costs	Days	1,573,455	36	858,888	0	29,401	16,049	9
10	24	Administrative Services Costs	Days	1,573,455	36	131,312	0	29,401	2,455	10
11	26	Administrative Services Costs	Days	1,573,455	36	5,953	0	29,401	112	11
12	27	Administrative Services Costs	Days	1,573,455	36	89,725	0	29,401	1,677	12
13	30	Administrative Services Costs	Days	1,573,455	36	62,915	0	29,401	1,176	13
14	31	Administrative Services Costs	Days	1,573,455	36	4,349	0	29,401	81	14
15	33	Administrative Services Costs	Days	1,573,455	36	32,625	0	29,401	610	15
16	34	Administrative Services Costs	Days	1,573,455	36	77,325	0	29,401	1,445	16
17	35	Administrative Services Costs	Days	1,573,455	36	1,849	0	29,401	35	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					$ 10,931,683	$ 8,463,587		$ 194,346	25

Facility Name & ID Number Granite Nursing and Rehabilitation Center, I # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	06/20/12	$ 5,194,800	$ 4,574,957	07/01/2047	0.0275	$ 127,128	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	$ 4,574,957			$ 127,128	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	$ 4,574,957			$ 127,128	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 23,112 Line # 34

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	108,100	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.)	$	101,025	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,075)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	106,070	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	98,995	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	92,882	8
	2014	95,277	9
	2015	103,384	10
	2016	103,007	11
	2017	101,025	12

The 2018 assessment was estimated to be a 5% increase over the 2017 assessment.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Granite Nursing and Rehabilitation Center, LLC 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 2017 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 2017.

	(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 Drive	$ 95,964.04	$ 95,964.04
2.	22-2-20-07-08-201-011	3500 Century Drive	$ 5,061.12	$ 5,061.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,025.16	$ 101,025.16

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. Capitalized Pre-opening Salaries, Benefits&Other Costs Incurred. Allocated via Related Org Cost & Reported Sch VII B
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	$ 667,365	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	9,671	12	9,671		232,098	14
15	Emergency Lighting			2006	2,033	85	12	85		2,033	15
16	Weatherproof Lighting			2006	5,470	228	12	228		5,470	16
17	Exhaust Hood			2006	8,017	334	12	334		8,017	17
18	Sign			2006	800		10			800	18
19	Utility Room Cabinet			2006	2,946	123	12	123		2,946	19
20	Plumbing and Mechanical repairs capitalized for Medicaid			2006	16,108		3			16,108	20
21	2 Sprinkler System Heads			2007	1,578	72	11	72		1,578	21
22	Concrete Sidewalk			2007	2,470		10			2,470	22
23	Mag Locks and Key Pads			2007	2,604		10			2,604	23
24	Physical Therapy Addition			2007	431,389	19,608	11	19,608		431,389	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	81,172	10	81,172		1,623,449	27
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails										28
29	Dry Pendants			2008	3,020	151	10	151		3,020	29
30	Window Treatments			2008	30,741		5			30,741	30
31	Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2			2008	882,074	44,104	10	44,104		882,074	31
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track										32
33	Facility Sign			2008	12,836	642	10	642		12,836	33
34	Roof			2008	132,870	6,643	10	6,643		132,870	34
35	Physical Therapy Costs capitalized for Medicaid			2008	6,100		3			6,100	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 553	9	$ 553	$	$ 9,950	37
38	Boiler Assessment (Asset #120 Addition)	2009	11,439	635	9	635		11,439	38
39	Satellite TV Equipment	2009	12,830	713	9	713		12,830	39
40	Garage Door	2009	662	37	9	37		662	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	4,590	8	4,590		73,440	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	87	7	87		1,219	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		1,124	48
49	(3) PTAC Units	2012	1,865		5			1,865	49
50	Concrete Catch Basin	2012	3,110	207	15	207		1,348	50
51	Piping and Floor Drain	2012	935	37	25	37		241	51
52	Concrete Patio & Storm Drain	2012	46,184	3,079	15	3,079		20,013	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	3,218	161	20	161		885	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		4,553	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		2,665	59
60	Roof Repair - Capitalized for Medicaid	2015	4,293	429	10	429		1,503	60
61	Generator Repair - Capitalized for Medicaid	2015	4,146	829	5	829		2,902	61
62	Maglocks for 2 Doors - Capitalized for Medicaid	2016	4,217	422	10	422		1,054	62
63	Labor and Materials to attempt repair/replace fire panel - Capital	2016	5,260	351	15	351		877	63
64	20 Ton Rooftop A/C unit	2016	19,578	1,958	10	1,958		4,895	64
65	Water softener scale control media - Capital for Medicaid	2017	4,283	857	5	857		1,285	65
66	Paint-AllHallways, ActivityRoom,&DiningRoom-Cap for MCD	2017	8,932	1,786	5	1,786		2,679	66
67	Dish Room -FRP walls, Quarry tile floor w/ moisture membrane	2017	22,466	899	25	899		1,348	67
68	Paint-Dietary Office,DiningRoom,Kitchen&SupplyRoom Cap for	2017	12,258	2,452	5	2,452		3,677	68
69	Sewer - sump pump cleaning,sewer lift repair - Capitalized for M	2017	9,123	912	10	912		1,368	69
70	TOTAL (lines 4 thru 69)		$ 7,535,108	$ 274,755		$ 274,755	$	$ 4,527,282	70

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 274,755		$ 274,755	$	$ 4,527,282	1
2	Generator Repair Capitalized for Medicaid	2018	3,296	329	5	329		329	2
3	Fire System Valve and Sprinkler Heads Cap for MCD	2018	5,087	102	25	102		102	3
4	Replace (8) Smoke Detectors Capitalized for MCD	2018	3,813	191	10	191		191	4
5									5
6									6
7									7
8									8
9									9
10	Note: See additional building improvements made by former		157,209	4,182		4,182		157,209	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)		$ 7,704,513	$ 279,559		$ 279,559	$	$ 4,685,113	34

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 163,495	$ 15,298	$ 15,298	$	various	$ 114,437	71
72	Current Year Purchases	23,717	1,527	1,527		various	1,527	72
73	Fully Depreciated Assets	328,763	7,892	7,892		various	328,763	73
74								74
75	TOTALS	$ 515,975	$ 24,717	$ 24,717	$		$ 444,727	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)	$ 8,530,458	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 304,276	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 304,276	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)	$ 5,129,840	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 Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 65,015 Description: see separate schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 ____

Facility requires new employees to be certified upon hiring.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 214,219	$	1
2	Cash-Patient Deposits	10,494		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	715,416		3
4	Supply Inventory (priced at cost)	9,506		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,147		6
7	Other Prepaid Expenses	4,904		7
8	Accounts Receivable (owners or related parties)	(267,982)		8
9	Other(specify): Non Resident A/R (see TB)	21,577		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 711,281	$	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	122,457		16
17	Accumulated Depreciation (book methods)	(122,531)		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)**	$ 118,397	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 829,678	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 134,485	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,668		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,770		30
31	Accrued Taxes Payable (excluding real estate taxes)	42,885		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(16,347)		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	32,006		36
37	Accrued Expenses	214,352		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 670,819	$	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)**	$ 670,819	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 158,859	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 829,678	$	48

***(See instructions.)**

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 76,683	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 76,683	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	101,176	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	124,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(143,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 82,176	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)**	$ 158,859	24 *

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 4,902,550	1
2	Discounts and Allowances for all Levels	1,044,702	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,947,252	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	7,272	5
6	Therapy	616,705	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 623,977	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	63	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,470	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,321	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,854	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	238	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 238	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Prior Year Net Revenue**	(28,871)	28
28a	**Purchase Discounts & Misc Revenue**	2,637	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (26,234)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,559,087	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,044,990	31
32	Health Care	3,135,627	32
33	General Administration	1,264,114	33
	B. Capital Expense		
34	Ownership	490,443	34
	C. Ancillary Expense		
35	Special Cost Centers	318,493	35
36	Provider Participation Fee	204,244	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,457,911	40
41	**Income before Income Taxes (line 30 minus line 40)****	101,176	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 101,176	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,992,317	44
45	Private Pay - Net Inpatient Revenue	650,022	45
46	Medicare - Net Inpatient Revenue	1,742,828	46
47	Other-(specify) **Hospice**	89,029	47
48	Other-(specify) **Medicare HMO**	473,056	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,947,252	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 Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,006	2,074	$ 83,553	$ 40.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,493	2,798	80,787	28.87	3
4	Licensed Practical Nurses	30,462	32,143	877,910	27.31	4
5	CNAs & Orderlies	60,091	64,416	848,175	13.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,826	1,956	29,761	15.22	9
10	Activity Assistants	1,789	1,882	20,375	10.83	10
11	Social Service Workers	1,824	1,936	51,066	26.38	11
12	Dietician					12
13	Food Service Supervisor	3,379	3,550	66,631	18.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,308	4,529	50,896	11.24	15
16	Dishwashers	12,547	13,331	130,725	9.81	16
17	Maintenance Workers	3,408	3,600	54,384	15.11	17
18	Housekeepers	12,778	14,065	158,096	11.24	18
19	Laundry	4,829	5,286	57,355	10.85	19
20	Administrator	1,752	1,912	77,782	40.68	20
21	Assistant Administrator	160	160	5,143	32.14	21
22	Other Administrative	3,861	4,161	83,937	20.17	22
23	Office Manager	1,852	2,146	44,991	20.97	23
24	Clerical	3,614	3,824	53,497	13.99	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	1,973	2,155	45,149	20.95	31
32	Other Health Care(specify)					32
33	Other(specify) Central Supply	1,208	1,353	19,176	14.17	33
34	TOTAL (lines 1 - 33)	156,160	167,277	$ 2,839,389 *	$ 16.97	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	178	18,000	9-3	36
37	Medical Records Consultant	48	3,360	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	203	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	37	2,390	11-3	44
45	Social Service Consultant	37	2,390	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	503	$ 44,716		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	597	$ 35,061	10-3	50
51	Licensed Practical Nurses	77	3,098	10-3	51
52	Certified Nurse Assistants/Aides	1,497	38,354	10-3	52
53	TOTAL (lines 50 - 52)	2,171	$ 76,513		53

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Plumb	Administrator	0	$ 77,782
Michelle Plumb	Asst. Administrator	0	5,143
B.Colp, D.Wallce	Bus. Office Mgr	0	16,945
Elizabeth Pelan	Bus. Office Mgr	0	28,046
J.Johnson,A.Ratcliff, A.Voyles	Bus. Office Asst	0	31,939
M.Fee, S. Cunningham	Human Resources	0	39,335
Dawn Steward	Admissions Director	0	44,602
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 243,792

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 201,084
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 201,084

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxic & Battalgia	Accounting Fees	$ 2,568
Freed, Maxic & Battalgia	Tax Fees	3,283
Various Legal Fees - See attached detailed listing		65,860
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 71,711

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,298
Unemployment Compensation Insurance	69,234
FICA Taxes	211,461
Employee Health Insurance	119,263
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Workers Compensation Safety Rec. Program	7,924
Employee Benefit -Holiday/Recognition	8,399
Employee Benefit - Short Term Disability	465
Employee Benefit - Employee Vaccinations	2,357
Employee Benefit - H.S.A (ER)	1,356
Employee Benefit - Life Insurance (ER)	88
Employee Benefit - Dental/Vision Ins (ER)	603
TOTAL (agree to Schedule V, line 22, col.8)	$ 483,448

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

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

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	6,424
Health Care Worker Background Check	90
(Indicate # of checks performed 6)	
Patient Background Checks 89	890
Facility Advertising	18,416
IL. Health Care Association/Chamber/Econ	7,344
Non-AllowHealthCareAssn/ChamberC	(2,810)
Fingerprinting	592
Citrix License Renew	1,302
Less: Public Relations Expense	( )
Non-allowable advertising	(18,416)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,822

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	31,232
Seminar Expense	1,792
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,024

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 $3,674 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. $ **30,306** 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. $ **204,244**
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? **Yes** Indicate the amount. $ **63**

(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 Nursing and Rehabilitation Center, LLC # 0046904 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	409	13	409		10,635	14
15	Replace Plumbing & Garbage Disposal			2005	6,767	260	13	260		6,767	15
16	Exhaust Fan - Laundry Area			2005	855		10			855	16
17	Doors (6)			2005	6,800	262	13	262		6,800	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	1,520	13	1,520		39,530	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)		10			(4,237)	25
26	Walk-in Cooler / Freezer			2006	31,667	1,259	12	1,259		31,667	26
27	Paint Exterior of Facility			2006	3,846		5			3,846	27
28	Plumbing Install Sinks (2)			2006	18,500	472	12	472		18,500	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	4,182		4,182		157,209	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 101,176 **
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.