

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

<p>I. IDPH License ID Number: <u>0046904</u></p> <p>Facility Name: <u>Granite Nsg Rehab Center</u></p> <p>Address: <u>3500 Century Drive</u> <u>Granite City</u> <u>62040</u> <small>Number City Zip Code</small></p> <p>County: <u>Madison</u></p> <p>Telephone Number: <u>(618) 877-2700</u> Fax # <u>(618) 877-0711</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>January 1, 2005</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Renee Klawon</u> Telephone Number: <u>(716) 972-2305</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ <u>6/29/2021</u> <small>(Date)</small></td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Pamela J Owens</u></td> </tr> <tr> <td></td> <td>(Title) <u>Executive Director</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ <small>(Date)</small></td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) () _____ Fax # () _____</td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ <u>6/29/2021</u> <small>(Date)</small>		(Type or Print Name) <u>Pamela J Owens</u>		(Title) <u>Executive Director</u>	Paid Preparer	(Signed) _____ <small>(Date)</small>		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) () _____ Fax # () _____																																						

Facility Name & ID Number Granite Nsg Rehab Center

0046904 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,975	2,610	5,530	26,115	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,975	2,610	5,530	26,115	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.97%

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

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

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 Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 86 and days of care provided 3,110

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 1/1 to 12/31/20 Fiscal Year: 1/1 to 12/31/20

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

Facility Name & ID Number Granite Nsg Rehab Center # 0046904 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	211,535	25,510	27,839	264,884		264,884	(1,016)	263,868		1
2	Food Purchase		157,426		157,426		157,426	(109)	157,317		2
3	Housekeeping	145,242	23,748	1,056	170,046		170,046		170,046		3
4	Laundry	49,299	33,811	1,346	84,456		84,456		84,456		4
5	Heat and Other Utilities			82,339	82,339		82,339		82,339		5
6	Maintenance	18,159	11,763	69,287	99,209		99,209	(3,450)	95,759		6
7	Other (specify):* see trial balance			52,564	52,564		52,564		52,564		7
8	TOTAL General Services	424,235	252,258	234,431	910,924		910,924	(4,575)	906,349		8
	B. Health Care and Programs										
9	Medical Director			20,341	20,341		20,341		20,341		9
10	Nursing and Medical Records	1,934,685	266,324	122,012	2,323,021		2,323,021	(34,565)	2,288,456		10
10a	Therapy		5,994	889,153	895,147		895,147	(134,941)	760,206		10a
11	Activities	55,609	2,346	1,887	59,842		59,842		59,842		11
12	Social Services	36,255		998	37,253		37,253		37,253		12
13	CNA Training										13
14	Program Transportation			8,071	8,071		8,071	(1,149)	6,922		14
15	Other (specify):* see trial balance			9,081	9,081		9,081	(3,338)	5,743		15
16	TOTAL Health Care and Programs	2,026,549	274,664	1,051,543	3,352,756		3,352,756	(173,993)	3,178,763		16
	C. General Administration										
17	Administrative	336,910		247,908	584,818		584,818	(20,712)	564,106		17
18	Directors Fees										18
19	Professional Services			105,209	105,209		105,209	(12,538)	92,671		19
20	Dues, Fees, Subscriptions & Promotions			43,458	43,458		43,458	(14,069)	29,389		20
21	Clerical & General Office Expenses	27,065	34,089	62,798	123,952		123,952	(7,477)	116,475		21
22	Employee Benefits & Payroll Taxes			564,499	564,499		564,499	(4,337)	560,162		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,057	14,057		14,057		14,057		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			173,234	173,234		173,234	(2,600)	170,634		26
27	Other (specify):* see trial balance			38,976	38,976		38,976	34,170	73,146		27
28	TOTAL General Administration	363,975	34,089	1,250,139	1,648,203		1,648,203	(27,563)	1,620,640		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,814,759	561,011	2,536,113	5,911,883		5,911,883	(206,131)	5,705,752		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:

01/01/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,454	14,454		14,454	104,957	119,411			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							121,245	121,245			32
33	Real Estate Taxes			108,204	108,204		108,204		108,204			33
34	Rent-Facility & Grounds			276,551	276,551		276,551	(254,522)	22,029			34
35	Rent-Equipment & Vehicles			59,320	59,320		59,320		59,320			35
36	Other (specify):* Off-site Storage			2,842	2,842		2,842		2,842			36
37	TOTAL Ownership			461,371	461,371		461,371	(28,320)	433,051			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			70	70		70		70			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,025	187,025		187,025		187,025			42
43	Other (specify):* see trial balance			221,573	221,573		221,573	(84,653)	136,920			43
44	TOTAL Special Cost Centers			408,668	408,668		408,668	(84,653)	324,015			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,814,759	561,011	3,406,152	6,781,922		6,781,922	(319,104)	6,462,818			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(36)	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	(73)	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	(887)	21		18
19	Entertainment				19
20	Contributions	(1,144)	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	29,816	27		24
25	Fund Raising, Advertising and Promotional	(10,833)	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	(73,973)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,130)		\$	30

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	2	
		Amount	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)	(261,974)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (261,974)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (319,104)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

Granite Nsg Rehab Center

ID# 0046904

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues & Subscriptions	\$ (3,081)	20	1
2	Remove Non-allowable Finance Charges	(392)	21	2
3	Remove Non-allow Admin-Credit Card Activation Fee	(5)	21	3
4	Remove Non-allowable Insurance Costs	(2,600)	26	4
5	Remove Non-allow Nrs Admin-Resident Transports	(1,149)	14	5
6	Remove -Non-allowable Admin - Legal	(9,982)	19	6
7	Remove Non Allowable - Acctg - Tax Fees	(2,556)	19	7
8	Remove Non-Allow Admin-TaxCreditSvcs (WOTC)	(824)	21	8
9	Remove Non-allowable Admin Other Supplies	(3,051)	21	9
10	Remove Non-allowable Prior Year Costs	(17,086)	43	10
11	Remove Non-allowable IV Prescription Drugs Costs	(12,329)	43	11
12	Offset Misc. Revenue	(3,579)	10	12
13	Offset Misc. Revenue	(50)	10	13
14	Offset Misc. Revenue	(733)	10	14
15	Offset Misc. Revenue	(33)	10	15
16	Offset Misc. Revenue	(57)	21	16
17	Offset Misc. Revenue	(14)	6	17
18	Offset Misc. Revenue	(1,016)	10	18
19	Offset Misc. Revenue	(1,016)	1	19
20	Offset Misc. Revenue	(1,016)	6	20
21	Offset Misc. Revenue	(809)	10	21
22	Offset Interco Sold Services Revenue	(444)	6	22
23	Offset Interco Sold Services Revenue	(1,976)	6	23
24	Offset Interco Sold Services Revenue	(13,470)	10	24
25	Offset Interco Sold Services Revenue	(1,134)	10	25
26	Offset Interco Sold Services Revenue	(329)	10	26
27	Offset Interco Sold Services Revenue	(502)	17	27
28	Offset Interco Sold Services Revenue	(72)	17	28
29	Offset Interco Sold Services Revenue	(2,034)	17	29
30	Offset Interco Sold Services Revenue	(4,210)	22	30
31	Offset Outpatient Physical Therapy Revenue	(1,445)	10a	31
32	Capitalize repairs & maintenance & equipment	(2,728)	10	32
33	Depreciation/Amortization LHI	9,475	30	33
34	Depreciation/Amortization MME	6,557	30	34
35	Current Year Depreciation Audit Adjustments LHI	(57)	30	35
36	Remove Non-allow HR-EE Background Check	(155)	20	36
37	Remove Non-allow Admin Other Direct	(31)	21	37
38	Remove Non-allow Admin-Awards/Gifts	(40)	21	38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73,973)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nsg Rehab Center

0046904

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,016)	0	0	0	0	0	0	0	0	0	0	(1,016)	1
2	Food Purchase	(109)	0	0	0	0	0	0	0	0	0	0	(109)	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	(3,450)	0	0	0	0	0	0	0	0	0	0	(3,450)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,575)	0	0	0	0	0	0	0	0	0	0	(4,575)	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	(23,881)	(10,684)	0	0	0	0	0	0	0	0	0	(34,565)	10
10a	Therapy	(1,445)	(133,496)	0	0	0	0	0	0	0	0	0	(134,941)	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	(1,149)	0	0	0	0	0	0	0	0	0	0	(1,149)	14
15	Other (specify):*	0	(3,338)	0	0	0	0	0	0	0	0	0	(3,338)	15
16	TOTAL Health Care and Programs	(26,475)	(147,518)	0	0	0	0	0	0	0	0	0	(173,993)	16
	C. General Administration													
17	Administrative	(2,608)	(18,104)	0	0	0	0	0	0	0	0	0	(20,712)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,538)	0	0	0	0	0	0	0	0	0	0	(12,538)	19
20	Fees, Subscriptions & Promotions	(14,069)	0	0	0	0	0	0	0	0	0	0	(14,069)	20
21	Clerical & General Office Expenses	(5,287)	(2,190)	0	0	0	0	0	0	0	0	0	(7,477)	21
22	Employee Benefits & Payroll Taxes	(4,210)	(127)	0	0	0	0	0	0	0	0	0	(4,337)	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):*	28,672	0	5,498	0	0	0	0	0	0	0	0	34,170	27
28	TOTAL General Administration	(12,640)	(20,421)	5,498	0	0	0	0	0	0	0	0	(27,563)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,690)	(167,939)	5,498	0	0	0	0	0	0	0	0	(206,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nsg Rehab Center

0046904

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	15,975	0	88,982	0	0	0	0	0	0	0	0	104,957	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	121,245	0	0	0	0	0	0	0	0	121,245	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(254,522)	0	0	0	0	0	0	0	0	(254,522)	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	15,975	0	(44,295)	0	0	0	0	0	0	0	0	(28,320)	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):*	(29,415)	(55,238)	0	0	0	0	0	0	0	0	0	(84,653)	43
44	TOTAL Special Cost Centers	(29,415)	(55,238)	0	0	0	0	0	0	0	0	0	(84,653)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(57,130)	(223,177)	(38,797)	0	0	0	0	0	0	0	0	(319,104)	45

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 Sol	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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Administrative Services Costs	\$ 247,908	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 229,804	\$ (18,104)	1
2	V	15 Wireless Access Points License Fee	992	RAImax Healthcare Solutions Group, LLC	0.00%	963	(29)	2
3	V	15 Patient Care Software	3,600	RAImax Healthcare Solutions Group, LLC	0.00%	291	(3,309)	3
4	V	21 Wireless Access Points License Fee		RAImax Healthcare Solutions Group, LLC	0.00%	334	334	4
5	V	21 Carrier Comm Rev Offset		RAImax Healthcare Solutions Group, LLC	0.00%	(2,524)	(2,524)	5
6	V	10 Pharmacy Consulting Services	17,286	Tara Pharmacy SE, LLC	0.00%	6,602	(10,684)	6
7	V	43 Flu Vac/Prescription Drug- Residents	156,165	Tara Pharmacy SE, LLC	0.00%	100,927	(55,238)	7
8	V	22 Vaccines for Employees	1,997	Tara Pharmacy SE, LLC	0.00%	1,870	(127)	8
9	V	10a Physical Therapy Fees	425,764	Tara Therapy, LLC	0.00%	303,010	(122,754)	9
10	V	10a Occupational Therapy Fees	328,136	Tara Therapy, LLC	0.00%	338,952	10,816	10
11	V	10a Speech Therapy Fees	128,443	Tara Therapy, LLC	0.00%	106,885	(21,558)	11
12	V							12
13	V							13
14	Total		\$ 1,310,291			\$ 1,087,114	\$ * (223,177)	14

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rent	\$ 276,550	Colonnades Property Company, LLC	0.00%	\$	\$ (276,550)
16	V	34 Mortgage Insurance Premium		Colonnades Property Company, LLC	0.00%	22,028	22,028
17	V	30 Depreciation Bldg & Improve		Colonnades Property Company, LLC	0.00%	88,982	88,982
18	V	27 Amort Loan Acquisition Costs		Colonnades Property Company, LLC	0.00%	5,498	5,498
19	V	32 Interest-Capital/Long-Term Debt		Colonnades Property Company, LLC	0.00%	121,245	121,245
20	V	6 Plant Operations	494	Stearns Nursing and Rehabilitation Center LCL	0.00%	494	
21	V	1 Dietary Services	24,247	Stearns Nursing and Rehabilitation Center LCL	0.00%	24,247	
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 301,291			\$ 262,494	\$ * (38,797)

* 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:

01/01/2020

Ending:

12/31/2020

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, I	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, LI	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,]	Jackson				18
19			Ruleville Nursing and Rehabilitation Center, LI	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 Nsg Rehab Center

0046904

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00		0	0.00		\$ 0	17	1
2	D & N, LLC	Owner		50.00		0	0.00		0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.58	1.45	Fin/ Adm. of TC	4,778	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CoCEO	Finance/ Admin	0.00	***	0.58	1.45	Fin/ Adm. of TC	4,778	17	5
6		for Tara Cares	of Tara Cares								6
7	Suzette Wilson	Vice President	Admin	0.00	***	0.58	1.45	VP of TC	3,757	17	7
8			of Tara Cares								8
9	Christopher Denz	Vice President	Tara Cares	0.00	***	0.58	1.45	VP of TC	1,137	17	9
10											10
11	*** Compensation paid only through Support Office and allocated share reported in column 7.										11
12											12
13								TOTAL	\$ 14,450		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:

01/01/2020

Ending: 2/31/2020

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Administrative Services Costs	Total Costs	39	\$ 387,083	\$ 294,025	6,527,987	\$ 6,190	1	
2	3	Administrative Services Costs	Days	1,475,555	36	1,807	26,105	32	2	
3	5	Administrative Services Costs	Days	1,475,555	36	28,542	26,105	505	3	
4	6	Administrative Services Costs	Days	1,475,555	36	231,425	103,937	4,098	4	
5	10	Administrative Services Costs	Total Costs	408,328,735	39	2,939,493	2,298,115	46,989	5	
6	17	Administrative Services Costs	Days	1,475,555	36	7,181,342	7,181,342	127,050	6	
7	19	Administrative Services Costs	Days	1,475,555	36	106,116	26,105	1,878	7	
8	20	Administrative Services Costs	Days	1,475,555	36	152,019	26,105	2,689	8	
9	21	Administrative Services Costs	Days	1,475,555	36	461,972	26,105	8,173	9	
10	22	Administrative Services Costs	Days	1,475,555	36	1,411,377	26,105	24,968	10	
11	24	Administrative Services Costs	Days	1,475,555	36	31,941	26,105	566	11	
12	26	Administrative Services Costs	Days	1,475,555	36	5,217	26,105	93	12	
13	27	Administrative Services Costs	Days	1,475,555	36	133,240	26,105	2,357	13	
14	30	Administrative Services Costs	Days	1,475,555	36	96,883	26,105	1,714	14	
15	33	Administrative Services Costs	Days	1,475,555	36	35,384	26,105	626	15	
16	34	Administrative Services Costs	Days	1,475,555	36	103,471	26,105	1,831	16	
17	35	Administrative Services Costs	Days	1,475,555	36	2,577	26,105	45	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 facility. 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				\$ 13,309,889	\$ 9,877,419		\$ 229,804	25	

Facility Name & ID Number

Granite Nsg Rehab Center

0046904

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	ORIX Real Estate Capital LLC		X	Land and Building	\$19,274.50	6/20/12	\$ 5,194,800	\$ 4,358,337	7/1/2047	0.0275	\$ 121,245	1						
2	dba Lument Capital											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	\$ 4,358,337			\$ 121,245	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	\$ 4,358,337			\$ 121,245	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,028 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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.)		\$	105,514	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,586)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	110,790	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.		\$	108,204	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	103,384	8
	2016	103,007	9
	2017	101,025	10
	2018	102,971	11
	2019	105,514	12

The 2020 assessment was estimated to be a 5% increase over the 2019 assessment.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 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 Renee Klawon

TELEPHONE (716) 972-2305 FAX #: (716) 972-0338

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>22-2-20-07-08-201-010</u>	<u>3500 Century Drive</u>	\$ <u>100,227.56</u>	\$ <u>100,227.56</u>
2. <u>22-2-20-07-08-201-011</u>	<u>3500 Century Drive</u>	\$ <u>5,286.48</u>	\$ <u>5,286.48</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>105,514.04</u></u>	\$ <u><u>105,514.04</u></u>

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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:

01/01/2020 Ending:

12/31/2020

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (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? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 6 columns: Line Item, Use, Square Feet, Year Acquired, Cost, and another column. Row 1: Long Term Care, 503,833, 2011, 309,970. Row 2: (blank), (blank), (blank), (blank). Row 3: TOTALS, 503,833, (blank), 309,970.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	86	2011	1964	\$ 3,559,279	\$ 88,982	40	\$ 88,982	\$	\$ 845,329	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		12			232,098	14
15	Emergency Lighting		2006	2,033		12			2,033	15
16	Weatherproof Lighting		2006	5,470		12			5,470	16
17	Exhaust Hood		2006	8,017		12			8,017	17
18	Sign		2006	800		10			800	18
19	Utility Room Cabinet		2006	2,946		12			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		11			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		11			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		10			1,623,449	27
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails									28
29	Dry Pendants		2008	3,020		10			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		10			882,074	31
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track									32
33	Facility Sign		2008	12,836		10			12,836	33
34	Roof		2008	132,870		10			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 Nsg Rehab Center

0046904

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Sewer Ejector Pump	2009	\$ 9,950	\$	9	\$	\$	\$ 9,950	37
38	Boiler Assessment (Asset #120 Addition)	2009	11,439		9			11,439	38
39	Satellite TV Equipment	2009	12,830		9			12,830	39
40	Garage Door	2009	662		9			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		8			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		7			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		1,470	48
49	(3) PTAC Units	2012	1,865		5			1,865	49
50	Concrete Catch Basin	2012	3,110	207	15	207		1,762	50
51	Piping and Floor Drain	2012	935	37	25	37		315	51
52	Concrete Patio & Storm Drain	2012	46,184	3,079	15	3,079		26,171	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		1,046	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		6,577	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		4,187	59
60	Roof Repair - Capitalized for Medicaid	2015	4,293	429	10	429		2,361	60
61	Generator Repair - Capitalized for Medicaid	2015	4,146	415	5	415		4,146	61
62	Maglocks for 2 Doors - Capitalized for Medicaid	2016	4,217	422	10	422		1,898	62
63	Labor and Materials to attempt repair/replace fire panel - Capital	2016	5,260	351	15	351		1,579	63
64	20 Ton Rooftop A/C unit	2016	19,578	1,958	10	1,958		8,811	64
65	Water softener scale control media - Capital for Medicaid	2017	4,283	857	5	857		2,999	65
66	Paint-AllHallways, ActivityRoom,&DiningRoom-Cap for MCD	2017	8,932	1,786	5	1,786		6,251	66
67	Dish Room -FRP walls, Quarry tile floor w/ moisture membrane	2017	22,466	899	25	899		3,146	67
68	Paint-Dietary Office,DiningRoom,Kitchen&SupplyRoom Cap for	2017	12,258	2,452	5	2,452		8,581	68
69	Sewer - sump pump cleaning,sewer lift repair - Capitalized for N	2017	9,123	912	10	912		3,192	69
70	TOTAL (lines 4 thru 69)		\$ 7,535,108	\$ 104,893		\$ 104,893	\$	\$ 4,737,321	70

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

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	\$ 104,893		\$ 104,893	\$	\$ 4,737,321	1
2	Generator Repair Capitalized for Medicaid	2018	3,296	659	5	659		1,647	2
3	Fire System Valve and Sprinkler Heads Cap for MCD	2018	5,087	203	25	203		508	3
4	Replace (8) Smoke Detectors Capitalized for MCD	2018	3,813	381	10	381		953	4
5	Generator Repair Capitalized for Medicaid	2019	3,040	608	5	608		912	5
6									6
7									7
8									8
9									9
10	Note: See additional building improvements made by former		157,209					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)		\$ 7,707,553	\$ 106,744		\$ 106,744	\$	\$ 4,898,550	34

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

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	\$ 107,569	\$ 11,422	\$ 11,422	\$	Various	\$ 58,798	71
72	Current Year Purchases	11,608	313	313		Various	313	72
73	Fully Depreciated Assets	412,617	932	932		Various	412,618	73
74								74
75	TOTALS	\$ 531,794	\$ 12,667	\$ 12,667	\$		\$ 471,729	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)	\$ 8,549,317	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,411	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,411	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)	\$ 5,370,279	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: 01/01/2020

Ending: 12/31/2020

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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 75,037 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Granite Nsg Rehab Center

0046904

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 916,612	\$	1
2	Cash-Patient Deposits	14,646		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	334,098		3
4	Supply Inventory (priced at)	7,163		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,203		6
7	Other Prepaid Expenses	6,563		7
8	Accounts Receivable (owners or related parties)	(132,979)		8
9	Other(specify): <u>Non-resident A/R-see TB</u>	11,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,160,306	\$	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	131,337		16
17	Accumulated Depreciation (book methods)	(152,397)		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 <u>Deposits-Long Term</u>)	1,100		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 96,954	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,257,260	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 143,663	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,637		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	182,918		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,271		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(22,031)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Employee Benefits Payable</u>	71,858		36
37	<u>Accrued Expenses</u>	465,393		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 888,709	\$	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)	\$ 888,709	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 368,551	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,257,260	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 323,054	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 323,054	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	739,820	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	9,593	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(703,916)	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)	\$ 45,497	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)	\$ 368,551	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Granite Nsg Rehab Center

0046904

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,797,072	1
2	Discounts and Allowances for all Levels	1,069,027	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,866,099	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	1,445	5
6	Therapy	793,304	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 794,749	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	36	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,430	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	208	19
20	Radiology and X-Ray		20
21	Other Medical Services	14,361	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,035	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,027	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,027	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	(66,202)	28
28a	Federal & State COVID Funds / Misc Revenues	902,034	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 835,832	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,521,742	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	910,924	31
32	Health Care	3,352,756	32
33	General Administration	1,648,203	33
B. Capital Expense			
34	Ownership	461,371	34
C. Ancillary Expense			
35	Special Cost Centers	221,643	35
36	Provider Participation Fee	187,025	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,781,922	40
41	Income before Income Taxes (line 30 minus line 40)**	739,820	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 739,820	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,261,251	44
45	Private Pay - Net Inpatient Revenue	491,349	45
46	Medicare - Net Inpatient Revenue	1,536,470	46
47	Other-(specify) Hospice	263,080	47
48	Other-(specify) Medicare HMO	313,949	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,866,099	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: 01/01/2020

Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,680	1,830	\$ 87,297	\$ 47.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,385	7,992	202,399	25.33	3
4	Licensed Practical Nurses	24,433	26,846	839,541	31.27	4
5	CNAs & Orderlies	45,982	49,303	749,391	15.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,876	1,948	31,209	16.02	9
10	Activity Assistants	2,086	2,281	24,400	10.70	10
11	Social Service Workers	1,807	1,982	36,255	18.29	11
12	Dietician					12
13	Food Service Supervisor	2,398	2,640	54,699	20.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,580	5,951	68,525	11.51	15
16	Dishwashers	8,003	8,662	88,311	10.20	16
17	Maintenance Workers	800	1,114	18,159	16.30	17
18	Housekeepers	10,576	11,468	145,242	12.66	18
19	Laundry	3,875	4,193	49,299	11.76	19
20	Administrator	2,024	2,260	127,068	56.22	20
21	Assistant Administrator					21
22	Other Administrative	3,995	4,203	123,904	29.48	22
23	Office Manager	1,800	2,066	49,723	24.07	23
24	Clerical	3,899	4,169	63,280	15.18	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	2,052	2,264	50,699	22.39	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Central Supply</u>	400	400	5,358	13.40	33
34	TOTAL (lines 1 - 33)	130,651	141,572	\$ 2,814,759 *	\$ 19.88	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	209	20,341	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	264	29,796	10-3	38
39	Pharmacist Consultant	194	17,286	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	12	1,013	11-3	44
45	Social Service Consultant	12	998	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	691	\$ 69,434		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	47	\$ 2,957	10-3	50
51	Licensed Practical Nurses	206	12,552	10-3	51
52	Certified Nurse Assistants/Aides	1,522	59,421	10-3	52
53	TOTAL (lines 50 - 52)	1,775	\$ 74,930		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Rebecca Garcia	Administrator	0	\$ 57,532	Workers' Compensation Insurance	\$ 208,218	IDPH License Fee	\$ 1,990				
Gina Graham	Administrator	0	6,085	Unemployment Compensation Insurance	21,260	Advertising: Employee Recruitment	20,011				
Tammy Von Yeast	Administrator	0	63,451	FICA Taxes	208,552	Health Care Worker Background Check	115				
Elizabeth lee	Bus Off Mgr	0	49,723	Employee Health Insurance	104,626	(Indicate # of checks performed 32)					
Amanda Voyles	Bus Off Asst	0	36,215	Employee Meals	0	Patient Background Checks	89				
Pamela Owens	HR/Payroll	0	57,243	Illinois Municipal Retirement Fund (IMRF)*	0	Fingerprinting	1,792				
Dawn Steward	Admiss Director	0	66,661	Worker Compensation Safety Rec. Program	1,730	Facility Advertisng	10,833				
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Benefit - Holiday/Recognition	5,101	Business License	100				
(List each licensed administrator separately.)			\$ 336,910	Employee Benefit - Short Term Disability	542	IL Health Care Assn/Chamber of Comm	7,572				
B. Administrative - Other				Employee Benefit - Employee Vaccinations	1,870	Non-allwHealthCareAssn/Chamber Comm	(3,081)				
Description			Amount	Employee Benefit - HSA ER/Tuition Reimb	5,563	Less: Public Relations Expense	()				
Tara Cares Administrative Services Fee			\$ 247,908	Employee Benefit - Life Insurance (ER)	0	Non-allowable advertising	(10,833)				
				Employee Benefit - Dental/Vission Ins (ER)	2,700	Yellow page advertising	()				
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 560,162	TOTAL (agree to Sch. V, line 20, col. 8)				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 247,908	E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
(Attach a copy of any management service agreement)				Description	Line #	Amount	G. Schedule of Travel and Seminar**				
C. Professional Services							Description	Amount			
Vendor/Payee	Type		Amount	None in allowable cost			Out-of-State Travel	\$			
Freed, Maxick & Battaglia	Accounting Fees		\$ 2,772	(column 8) of Schedule V							
Freed, Maxick & Battaglia	Tax Fees		2,556				In-State Travel	13,870			
Various Legal Fees - See attached detailed listing			99,881								
							Seminar Expense	187			
							Entertainment Expense	()			
							(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 14,057			
(For legal fee disclosure, see page 39 of instructions)			\$ 105,209								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Granite Nsg Rehab Center

0046904

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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 \$4,490 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? 13
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,017 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. \$ 187,025
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 svcs 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. \$ 36
- (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? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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 of Change of Ownership)									9
10									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		13			10,635	14
15	Replace Plumbing & Garbage Disposal		2005	6,767		13			6,767	15
16	Exhaust Fan - Laundry Area		2005	855		10			855	16
17	Doors (6)		2005	6,800		13			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		13			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		12			31,667	26
27	Paint Exterior of Facility		2006	3,846		5			3,846	27
28	Plumbing Install Sinks (2)		2006	18,500		12			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					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

Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC **0046904**

Report Period Beginning: 1/1/2020 **Ending:** 12/31/2020

XVII. INCOME STATEMENT

Page 19 Note

Line 41 Income before Income Taxes 739,820 **

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.