

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 Granite City 62040 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 Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Gary F. Eye Telephone Number: (716) 662-4955 ext 392 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 01/01/11 to 12/31/11 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) 04/30/12 (Date) (Type or Print Name) Gary F. Eye (Title) Senior VP of Finance of Tara Cares Paid Preparer (Signed) (Date) (Print Name and Title) (Firm Name & Address) (Telephone) () Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Granite Nursing and Rehabilitation Center, LLC

0046904 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	31,390	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,950	6,868	7,640	28,458	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,950	6,868	7,640	28,458	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.66%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) outpatient therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

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 01/01/05

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date January 1, 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 4,554

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 12/31/11 Fiscal Year: 1/1 to 12/31/11
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS												
Facility Name & ID Number		Granite Nursing and Rehabilitation Center, I				#	0046904	Report Period Beginning:		01/01/11	Ending:	Page 3 12/31/11
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	160,434	16,629	16,932	193,995		193,995	(722)	193,273			1
2	Food Purchase		156,174		156,174		156,174	(181)	155,993			2
3	Housekeeping	134,370	17,193		151,563		151,563		151,563			3
4	Laundry	30,846	11,207	168	42,221		42,221		42,221			4
5	Heat and Other Utilities			111,487	111,487		111,487	(1,620)	109,867			5
6	Maintenance	24,068	16,918	59,812	100,798		100,798	(13,415)	87,383			6
7	Other (specify):* see trial balance			18,711	18,711		18,711	(8)	18,703			7
8	TOTAL General Services	349,718	218,121	207,110	774,949		774,949	(15,946)	759,003			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,671,185	119,736	27,176	1,818,097		1,818,097	(6,455)	1,811,642			10
10a	Therapy		6,954	1,035,529	1,042,483		1,042,483	(134,631)	907,852			10a
11	Activities	34,632	1,977	2,730	39,339		39,339		39,339			11
12	Social Services	33,830	575	1,480	35,885		35,885		35,885			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* see trial balance			4,914	4,914		4,914	(1,267)	3,647			15
16	TOTAL Health Care and Programs	1,739,647	129,242	1,081,429	2,950,318		2,950,318	(142,353)	2,807,965			16
	C. General Administration											
17	Administrative	234,264		320,940	555,204		555,204	(120,445)	434,759			17
18	Directors Fees											18
19	Professional Services			39,398	39,398		39,398	(2,568)	36,830			19
20	Dues, Fees, Subscriptions & Promotions			25,983	25,983		25,983	(12,635)	13,348			20
21	Clerical & General Office Expenses		27,803	27,570	55,373		55,373	(4,696)	50,677			21
22	Employee Benefits & Payroll Taxes			364,663	364,663		364,663	(4,689)	359,974			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,422	23,422		23,422	(63)	23,359			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			180,542	180,542		180,542	(2,600)	177,942			26
27	Other (specify):* see trial balance			58,140	58,140		58,140	16,782	74,922			27
28	TOTAL General Administration	234,264	27,803	1,040,658	1,302,725		1,302,725	(130,914)	1,171,811			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,323,629	375,166	2,329,197	5,027,992		5,027,992	(289,213)	4,738,779			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			213,970	213,970		213,970	262,966	476,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							88,918	88,918			32
33	Real Estate Taxes			86,119	86,119		86,119		86,119			33
34	Rent-Facility & Grounds			300,806	300,806		300,806	(253,260)	47,546			34
35	Rent-Equipment & Vehicles			30,691	30,691		30,691	1,272	31,963			35
36	Other (specify):*											36
37	TOTAL Ownership			631,586	631,586		631,586	99,896	731,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			477	477		477		477			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):* see trial balance			177,182	177,182		177,182	(44,910)	132,272			43
44	TOTAL Special Cost Centers			224,744	224,744		224,744	(44,910)	179,834			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,323,629	375,166	3,185,527	5,884,322		5,884,322	(234,227)	5,650,095			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(14,206)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,620)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(98)	32		10
11	Discounts, Allowances, Rebates & Refunds	(105)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(178)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,983)	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	7,984	27		24
25	Fund Raising, Advertising and Promotional	(12,635)	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	(36,872)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,716)		\$	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)	104,490		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (171,511)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (234,227)		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

Report Period Beginning:
Ending:

ID# 0046904
01/01/11
12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Remove Non-allowable EE Recognition Program	\$ (990)	22	1
2	Remove Non-allowable Visa Costs	(63)	24	2
3	Remove Non-allowable Visa Costs	(250)	22	3
4	Remove Non-allowable Admiss-Other Supplies	(4,588)	21	4
5	Remove Non-allowable Insurance Costs	(2,600)	26	5
6	Accrue Allowable NRS Admin-Rental/Lease	1,272	35	6
7	Remove Non-allowable NRS Admin-Purch Svcs	(496)	15	7
8	Remove Non-allowable Acctg - Tax Fees	(2,568)	19	8
9	Remove Non-allowable Admin-Purchased Srvcs	(3,767)	27	9
10	Remove Non-allowable Dental-Physician Fees	(200)	43	10
11	Remove Non-allowable Prior Year Costs	(1,251)	43	11
12	Remove Non-allowable IV Prescription Drugs	(4,903)	43	12
13	Offset Misc. Revenue Sch XVII line 28a	(514)	10	13
14	Offset Misc. Revenue Sch XVII line 28a	(18)	10	14
15	Offset Misc. Revenue Sch XVII line 28a	(48)	6	15
16	Offset Misc. Revenue Sch XVII line 28a	(347)	10	16
17	Offset Misc. Revenue Sch XVII line 28a	(95)	10	17
18	Offset Misc. Revenue Sch XVII line 28a	(3)	21	18
19	Offset Misc. Revenue Sch XVII line 28a	(8)	7	19
20	Offset Misc. Revenue Sch XVII line 28a	(99)	32	20
21	Offset Interco Sold Service Rev Sch XVII ln 28a	(5,632)	10	21
22	Offset Interco Sold Service Rev Sch XVII ln 28a	(117)	17	22
23	Offset Interco Sold Service Rev Sch XVII ln 28a	(333)	17	23
24	Offset Interco Sold Service Rev Sch XVII ln 28a	(631)	17	24
25	Offset Interco Sold Service Rev Sch XVII ln 28a	(2,725)	22	25
26	Offset Outpatient Occupational Therapy Rev	(3,667)	10a	26
27	Capitalize repairs&maint for Medicaid	(8,002)	6	27
28	Capitalize repairs&maint for Medicaid	(5,365)	6	28
29	Amort/Depreciate Repair/Maint Captl. For Medicaid	11,136	30	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(36,872)		49

Summary B

12/31/11

[illegible]

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	Colonnades Property Co	Granite City	Property Company
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Stearns Property Com	Granite City	Property Company
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Hardin Property Com	Hardin	Property Company
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Herculaneum Property	Herculaneum	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Jefferson City Propert	Jefferson City	Property Company
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Riverside Property Co	Kansas City	Property Company
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Terrace Square (Doug	Douglasville	Property Company

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	\$ 320,940	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 201,576	\$ (119,364)	1
2	V	34	Sublease Building & Equip	47,546	Tara Midwest, LLC	0.00%	47,546		2
3	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	2,850	(750)	3
4	V	10	Pharmacy Consulting Services	18,576	Tara Pharmacy SE, LLC	0.00%	19,009	433	4
5	V	43	Flu Vac/Prescription Drug- Residents	148,857	Tara Pharmacy SE, LLC	0.00%	110,301	(38,556)	5
6	V	22	Flu & Hep B Vaccine for Employees	2,100	Tara Pharmacy SE, LLC	0.00%	1,376	(724)	6
7	V	10	Medication Administration Records	5,676	Tara Pharmacy SE, LLC	0.00%	5,394	(282)	7
8	V	10a	Physical Therapy Fees	385,900	Tara Therapy, LLC	0.00%	339,162	(46,738)	8
9	V	10a	Occupational Therapy Fees	441,430	Tara Therapy, LLC	0.00%	390,219	(51,211)	9
10	V	10a	Speech Therapy Fees	206,281	Tara Therapy, LLC	0.00%	187,472	(18,809)	10
11	V	15	Nursing Services	168	Stearns Nursing and Rehabilitation Center, LLC	0.00%	147	(21)	11
12	V	1	Dietary Services	12,308	Stearns Nursing and Rehabilitation Center, LLC	0.00%	11,586	(722)	12
13	V								13
14	Total			\$ 1,593,382			\$ 1,316,638	\$ * (276,744)	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	\$253,260	Colonnades Property Company, LLC	0.00%	\$	(253,260)	15
16	V	30	Depreciation Leasehold Imp		Colonnades Property Company, LLC	0.00%	188,666	188,666	16
17	V	30	Depreciation Major Moveable		Colonnades Property Company, LLC	0.00%	18,673	18,673	17
18	V	30	Depreciation Bldg & Improve		Colonnades Property Company, LLC	0.00%	44,491	44,491	18
19	V	27	Amort Loan Acquisition Costs		Colonnades Property Company, LLC	0.00%	17,548	17,548	19
20	V	32	Interest-Capital/Long-Term Debt		Colonnades Property Company, LLC	0.00%	89,115	89,115	20
21	V								21
22	V								22
23	V								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			\$253,260			\$358,493	\$ *105,233	39

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

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	Jonesboro Property Co	Jonesboro	Property Company	1
2			Lake City Nursing and Rehabilitation Center, L	Lake City	Rex Road Property Co	Lake City	Property Company	2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile	Mobile Property Comp	Mobile	Property Company	3
4			Fairfield Nursing and Rehabilitation Center, LL	Fairfield	Fairfield Property Cor	Fairfield	Property Company	4
5			Florence Nursing and Rehabilitation Center, LL	Florence	Florence Property Cor	Florence	Property Company	5
6			Birmingham Nrs&Rehab Center East, LLC	Birmingham	Birmingham East Prop	Birmingham	Property Company	6
7			Birmingham Nursing and Rehabilitation Center,	Birmingham	Birmingham Property	Birmingham	Property Company	7
8			Eight Mile Nursing and Rehabilitation Center, L	Eight Mile	Eight Mile Property C	Eight Mile	Property Company	8
9			Quince Nursing and Rehabilitation Center, LLC	Memphis	Quince Property Comp	Memphis	Property Company	9
10			Allenbrooke Nursing and Rehabilitation Center,	Memphis	Allenbrooke Property	Memphis	Property Company	10
11			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo	Tupelo Property Comp	Tupelo	Property Company	11
12			Brandon Nursing and Rehabilitation Center, LL	Brandon	Brandon Property Cor	Brandon	Property Company	12
13			Lakeland Nursing and Rehabilitation Center, LI	Jackson	Lakeland Property Co	Jackson	Property Company	13
14			McComb Nursing and Rehabilitation Center, LI	McComb	McComb Property Co	McComb	Property Company	14
15			Cleveland Nursing and Rehabilitation Center, L	Cleveland	Cleveland Property Co	Cleveland	Property Company	15
16			Chadwick Nursing and Rehabilitation Center, L	Jackson	Chadwick (Jackson) P	Jackson	Property Company	16
17			Manhattan Nursing and Rehabilitation Center, I	Jackson	Manhattan Property C	Jackson	Property Company	17
18			Ruleville Nursing and Rehabilitation Center, LL	Ruleville	Ruleville Property Cor	Ruleville	Property Company	18
19			Farmerville Nursing and Rehabilitation Center,	Farmerville	Farmerville Property C	Farmerville	Property Company	19
20			Bernice Nursing and Rehabilitation Center, LLC	Bernice	Bernice Property Com	Bernice	Property Company	20
21			Ruston Nursing and Rehabilitation Center, LLC	Ruston	Longleaf (Ruston) Pro	Ruston	Property Company	21
22			Natchitoches Nursing and Rehabilitation Center,	Natchitoches	Natchitoches Property	Natchitoches	Property Company	22
23			Winnfield Nursing and Rehabilitation Center, L	Winnfield	Winnfield Property Co	Winnfield	Property Company	23
24			Ringgold Nursing and Rehabilitation Center, LI	Ringgold	Ringgold Property Cor	Ringgold	Property Company	24
25			Arcadia Nursing and Rehabilitation Center, LL	Arcadia	Willow Ridge (Arcadia	Arcadia	Property Company	25
26			Jena Nursing and Rehabilitation Center, LLC	Jena	Aimwell (Jena) Proper	Jena	Property Company	26
27					Aurora Cares Property	Orchard Park	Property Company	27
28			** The above listed facilites are related by		Aurora Cares, LLC d/	Orchard Park	Support Office	28
29			common ownership		Tara Midwest, LLC	Orchard Park	Subleases Bldg&Eq	29
30					Tara Healthcare, LLC	Orchard Park	Subleases Bldg&Eq	30

This page may also be used to list the Board of Directors for non-profit facilities. In the "Ownership %", enter "BOD".
IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1		2		3			
	OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Tara Pharmacy SE, LI	Birmingham	Pharmacy	1
2					Tara Therapy, LLC	Orchard Park	Therapy	2
3					Raimax Healthcare So	Orchard Park	Software	3
4					White Hall Property C	White Hall	Property Company	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	\$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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: 01/01/11 Ending: 12/31/11

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	Days	1,438,901	36	\$ 238,080	\$ 220,332	28,446	\$ 4,707	1
2	5	Administrative Services Costs	Days	1,438,901	36	32,904	0	28,446	650	2
3	6	Administrative Services Costs	Days	1,438,901	36	59,825	1,412	28,446	1,183	3
4	10	Administrative Services Costs	Days	1,438,901	36	2,062,719	1,958,819	28,446	40,778	4
5	17	Administrative Services Costs	Days	1,438,901	36	5,701,164	5,701,164	28,446	112,706	5
6	19	Administrative Services Costs	Days	1,438,901	36	15,009	0	28,446	297	6
7	20	Administrative Services Costs	Days	1,438,901	36	14,140	0	28,446	280	7
8	21	Administrative Services Costs	Days	1,438,901	36	282,582	0	28,446	5,586	8
9	22	Administrative Services Costs	Days	1,438,901	36	1,301,441	0	28,446	25,729	9
10	24	Administrative Services Costs	Days	1,438,901	36	120,117	0	28,446	2,375	10
11	26	Administrative Services Costs	Days	1,438,901	36	6,145	0	28,446	121	11
12	27	Administrative Services Costs	Days	1,438,901	36	70,082	0	28,446	1,385	12
13	30	Administrative Services Costs	Days	1,438,901	36	159,143	0	28,446	3,146	13
14	31	Administrative Services Costs	Days	1,438,901	36	5,670	0	28,446	112	14
15	33	Administrative Services Costs	Days	1,438,901	36	27,413	0	28,446	542	15
16	34	Administrative Services Costs	Days	1,438,901	36	99,870	0	28,446	1,974	16
17	35	Administrative Services Costs	Days	1,438,901	36	236	0	28,446	5	17
18										18
19		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								19
20		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								20
21		considered a Home Office by CMS and as defined in 42 CRF 421.404.								21
22										22
23										23
24										24
25	TOTALS					\$ 10,196,540	\$ 7,881,727		\$ 201,576	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	M&T Bank		X	Purchase of Physical Plant	\$14,167.00	6/22/11	\$ 4,457,878	\$ 4,457,878	7/22/13	0.0380	\$ 89,115	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$14,167.00		\$ 4,457,878	\$ 4,457,878			\$ 89,115	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,457,878	\$ 4,457,878			\$ 89,115	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line # N/A

* 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	<u>Granite Nursing and Rehabilitation Center, LLC</u>	COUNTY	<u>Madison</u>
FACILITY IDPH LICENSE NUMBER	<u>0046904</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Gary F. Eye</u>		
TELEPHONE	<u>(716) 662-4955, ext. 392</u>	FAX #:	<u>(716) 662-4468</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

A. Square Feet: 31,856

B. General Construction Type: Exterior Brick Frame Number of Stories one

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (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).

N/A

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: 131,730

2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)

3. Current Period Amortization: Included in Schedule VII B Ln 1-8

4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc.capitalized pre-opening salaries, fringe benefits&other costs incurred prior 1/1/06.Costs allocated via related org cost&reported on Sch VII

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

XI. OWNERSHIP COSTS:

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

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	\$ 44,491	40	\$ 44,491		\$ 44,491
5										
6										
7										
8										
	Improvement Type**									
9	Plumbing and Mechanical repairs capitalized for Medicaid			2005	7,645		3			7,645
10	Paint - Kitchen			2006	4,500	450	5	450		4,500
11	Paint Center of Building			2006	37,005	3,700	5	3,700		37,004
12	Window Treatment			2006	5,089	509	5	509		5,089
13	20 Ton HVAC Unit			2006	20,160	2,016	10	2,016		11,088
14	Sprinkler System			2006	232,098	19,342	12	19,342		106,379
15	Emergency Lighting			2006	2,034	169	12	169		932
16	Weatherproof Lighting			2006	5,470	456	12	456		2,507
17	Exhaust Hood			2006	8,017	668	12	668		3,674
18	Sign			2006	800	80	10	80		440
19	Utility Room Cabinet			2006	2,946	245	12	245		1,350
20	Plumbing and Mechanical repairs capitalized for Medicaid			2006	16,108		3			16,108
21	2 Sprinkler System Heads			2007	1,578	143	11	143		645
22	Concrete Sidewalk			2007	2,470	247	10	247		1,112
23	Mag Locks and Key Pads			2007	2,604	260	10	260		1,171
24	Physical Therapy Addition			2007	431,389	39,217	11	39,217		176,477
25	Plumbing and Mechanical repairs capitalized for Medicaid			2007	20,861		3			20,861
26	Generator			2007	146,483	29,297	5	29,297		102,538
27	Mechanical/Electrical Systems Upgrade & Significant Bldg Improvements			2008	1,623,449	162,345	10	162,345		568,208
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails									
29	Dry Pendants			2008	3,020	302	10	302		1,057
30	Window Treatments			2008	30,741	6,148	5	6,148		21,518
31	Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2			2008	882,074	88,207	10	88,207		308,725
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track									
33	Facility Sign			2008	12,836	1,284	10	1,284		4,493
34	Roof			2008	132,870	13,287	10	13,287		46,505
35	Physical Therapy Costs capitalized for Medicaid			2008	6,100	1,017	3	1,017		6,100
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

XI. OWNERSHIP COSTS (continued)

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

1	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	\$ 1,106	9	\$ 1,106	\$	\$ 2,764	37
38 Boiler Assessment (Asset #120 Addition)	2009	11,439	1,271	9	1,271		3,178	38
39 Satellite TV Equipment	2009	12,830	1,426	9	1,426		3,564	39
40 Garage Door	2009	662	74	9	74		184	40
41 Generator and Carrier Air Handler rpr Capitalized for Medicaid	2009	6,331	2,110	3	2,110		5,275	41
42 Boiler System Replacement	2010	73,440	9,180	8	9,180		13,770	42
43 A/C Unit (4)	2010	2,291	458	5	458		687	43
44 Boiler system repairs and concrete repairs to exits/stairwells								44
45 Capitalized for Medicaid	2010	17,342	5,781	3	5,781		8,671	45
46 Sewage Pump	2011	1,219	87	7	87		87	46
47 Boiler/Heater/Call Light System rpr Capitalized for Medicaid	2011	13,367	2,228	3	2,228		2,228	47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 7,346,495	\$ 437,601		\$ 437,601	\$	\$ 1,541,025	70

**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	\$287,774	\$36,791	\$36,791	\$	various	\$128,746	71
72	Current Year Purchases	22,199	2,544	2,544		various	2,544	72
73	Fully Depreciated Assets	48,434				various	48,434	73
74								74
75	TOTALS	\$358,407	\$39,335	\$39,335	\$		\$179,724	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$8,014,872	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$476,936	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$476,936	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)	\$1,720,749	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Health Care REIT, Inc. for the period 1/1/11 thru 6/22/11
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:	1964	86	01/01/05	\$ 47,546	6.5 years	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		86		\$ 47,546			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:exercised June 22, 2011*

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: \$ 34,085Description: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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning01/01/05

Ending06/22/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$ N/A
13.	/2013	\$ N/A
14.	/2014	\$ N/A

* 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.

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

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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.

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	\$ 28,366	\$	1
2	Cash-Patient Deposits	21,851		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,002,257		3
4	Supply Inventory (priced at cost)	7,514		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,031		6
7	Other Prepaid Expenses	4,601		7
8	Accounts Receivable (owners or related parties)	(3,325,272)		8
9	Other(specify): Non resident A/R (see TB)	(2,240)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (2,260,892)	\$	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			15
16	Equipment, at Historical Cost	10,391		16
17	Accumulated Depreciation (book methods)	(1,125)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(69)		21
22	Other Long-Term Assets (specify) Deposits long term	1,100		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,297	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (2,250,595)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 60,949	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,170		28
29	Short-Term Notes Payable	4,495		29
30	Accrued Salaries Payable	184,423		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,870		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,130		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	4,624		36
37	Accrued Expenses	209,802		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 602,463	\$	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)	\$ 602,463	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,853,058)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (2,250,595)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (437,591)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (437,591)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	210,162	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	501,857	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,127,486)	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)	\$ (2,415,467)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,853,058)	24 *

* This must agree with page 17, line 47.

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,646,262	1
2	Discounts and Allowances for all Levels	1,624,975	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,271,237	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	17,873	5
6	Therapy	779,197	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 797,070	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	3	14
15	Telephone, Television and Radio	1,620	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,840	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	187	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,650	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	117	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 117	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	11,333	28
28a	Purchase Discounts/Sold Srvcs Rev/Rebates	11,077	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,410	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,094,484	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	774,949	31
32	Health Care	2,950,318	32
33	General Administration	1,302,725	33
	B. Capital Expense		
34	Ownership	631,586	34
	C. Ancillary Expense		
35	Special Cost Centers	177,659	35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,884,322	40
41	Income before Income Taxes (line 30 minus line 40)**	210,162	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 210,162	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? [see attached](#) If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

		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	2,048	2,080	\$ 94,919	\$ 45.63	1
2	Assistant Director of Nursing	1,096	1,227	30,468	24.83	2
3	Registered Nurses	4,351	4,618	117,178	25.37	3
4	Licensed Practical Nurses	26,632	28,577	593,509	20.77	4
5	CNAs & Orderlies	60,225	64,350	686,112	10.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,856	2,064	21,378	10.36	9
10	Activity Assistants	1,393	1,423	13,254	9.31	10
11	Social Service Workers	1,956	2,080	33,830	16.26	11
12	Dietician					12
13	Food Service Supervisor	1,956	2,080	32,256	15.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,091	5,623	47,418	8.43	15
16	Dishwashers	8,546	9,310	80,760	8.67	16
17	Maintenance Workers	1,702	1,875	24,068	12.84	17
18	Housekeepers	12,952	13,864	134,370	9.69	18
19	Laundry	2,784	3,409	30,846	9.05	19
20	Administrator	3,412	3,787	132,375	34.96	20
21	Assistant Administrator					21
22	Other Administrative	2,021	2,157	34,968	16.21	22
23	Office Manager	1,960	2,080	42,094	20.24	23
24	Clerical	1,925	2,133	24,827	11.64	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					31
32	Other Health Care MDS	3,498	4,073	96,093	23.59	32
33	Other(specify) NRS Adm Clerical	3,893	4,338	52,906	12.20	33
34	TOTAL (lines 1 - 33)	149,297	161,148	\$ 2,323,629 *	\$ 14.42	34

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	624	9,600	9-3	36
37	Medical Records Consultant	45	2,756	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18/bed	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	23	1,480	11-3	44
45	Social Service Consultant	23	1,480	12-3	45
46	Other(specify)				46
47	Medical Adm Record Preparation	\$5.50/bed	5,676	10-3	47
48					48
49	TOTAL (lines 35 - 48)	714	\$ 39,568		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries	D. Employee Benefits and Payroll Taxes	F. Dues, Fees, Subscriptions and Promotions
Name Function % Amount	Description Amount	Description Amount
Mark JeffriesAdministrator0\$100,014	Workers' Compensation Insurance\$27,064	IDPH License Fee\$1,991
Laura BartonBus. Office Mgr042,666	Unemployment Compensation Insurance66,393	Advertising: Employee Recruitment3,506
Barbara J. ColpHR/Payroll025,241	FICA Taxes173,948	Health Care Worker Background Check5,867
Maria KwartaHR/Payroll021,481	Employee Health Insurance78,086	(Indicate # of checks performed306)
Cherrell GallionHR/Payroll09,359	Employee Meals0	Facility Advertising9,135
Miranda ScogginsAdmiss. Coordinator0943	Illinois Municipal Retirement Fund (IMRF)*0	IL. Health Care Assoc. Dues4,747
Dawn StewardAdmiss. Coordinator034,560	Worker Compensation Safety Rec. Prog.2,600	Non Allowable IL Health Care Assn(3,102)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)\$234,264	Employee Benefits - other11,058	Licenses / Permits/IL Administrator Assoc339
B. Administrative - Other	Employee Benefits - Short Term Disability825	Chamber of Commerce398
DescriptionAmount	Employee Benefits - Hepatitis B Vaccination0	Non Allow Chamber of Commerce(398)
Tara Cares Administrative Services Fee\$320,940		Less: Public Relations Expense()
		Non-allowable advertising(9,135)
		Yellow page advertising()
TOTAL (agree to Schedule V, line 17, col. 3)\$320,940	TOTAL (agree to Schedule V, line 22, col.8)\$359,974	TOTAL (agree to Sch. V, line 20, col. 8)\$13,348
C. Professional Services	E. Schedule of Non-Cash Compensation Paid to Owners or Employees	G. Schedule of Travel and Seminar**
Vendor/PayeeTypeAmount	DescriptionLine #Amount	DescriptionAmount
Freed, Maxick & BattagliaAccounting Fees\$2,318	None in Allowable cost\$	Out-of-State Travel\$
Freed, Maxick & BattagliaTax Fees2,568	(Column 8) of Schedule V	
Various Legal Expenses - See Attached detailed listing34,512		In-State Travel20,049
		Seminar Expense3,310
		Entertainment Expense()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)\$39,398	TOTAL\$	TOTAL (agree to Sch. V, line 24, col. 8)\$23,359

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		Granite Nursing and Rehabilitation Center, LLC		STATE OF ILLINOIS	#	0046904	Report Period Beginning:	01/01/11	Ending:	12/31/11	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>							
	If YES, give association name and amount.			<u>IHCA \$1,644 net of non allowable</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>Yes</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?			<u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>10</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>31,164</u> Line <u>10-2</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.										
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES NO <u>X</u>							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.			\$ <u>47,085</u>							
	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?			<u>No</u>							
	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?			<u>Yes</u>							
(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?			<u>Yes-outpatient therapy</u>							
	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.			\$ <u>None</u>							
	Has any meal income been offset against related costs?			<u>Yes</u>							
	Indicate the amount.			\$ <u>3</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>N/A</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>No</u>							
	Firm Name:			<u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?			<u>Yes</u>							
	Attach invoices and a summary of services for all architect and appraisal fees										

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1			\$	\$		\$	\$	\$	1
2	Improvements Made by Healthcare REIT (covered by rent at outset								2
3	of Change of Ownership)								3
4									4
5	Aspire Telephone System	2005	7,542	754	10	754		4,902	5
6	Garage Door	2005	536	53	10	53		348	6
7	Ductwork Removal & Installation	2005	10,635	818	13	818		5,318	7
8	Replace Plumbing & Garbage Disposal	2005	6,767	520	13	520		3,383	8
9	Exhaust Fan - Laundry Area	2005	855	86	10	86		556	9
10	Doors (6)	2005	6,800	523	13	523		3,400	10
11	Air Conditioning Units (3)	2005	3,294		5			3,294	11
12	Carpeting	2005	587		5			587	12
13	Roof Repairs - New Gutters and Facia	2005	4,850	485	10	485		3,153	13
14	Fire Damper	2005	1,250	125	10	125		812	14
15	Pave Walkway	2005	5,714	714	8	714		4,643	15
16	Replace 140' Sewer & Floor	2005	39,530	3,041	13	3,041		19,765	16
17	Floor Replacement Cost @ 6/30/06	2006	17,434	1,320	10	1,320		7,258	17
18	Floor Replacement Addl Cost Post 6/30/06	2006	(4,237)						18
19	Walk-in Cooler / Freezer	2006	31,667	2,639	12	2,639		14,514	19
20	Paint Exterior of Facility	2006	3,847	385	5	385		3,847	20
21	Plumbing Install Sinks (2)	2006	18,500	1,542	12	1,542		8,479	21
22	Carpeting	2006	1,639	164	5	164		1,639	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 157,209	\$ 13,169		\$ 13,169	\$ 0	\$ 85,898	34

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