

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0046904

Facility Name: Granite Nsg & Rehab Center

Address: 3500 Century Drive Granite City 62040
 Number City Zip Code

County: Madison

Telephone Number: (618) 877-2700 **Fax #** (618) 877-0711

HFS ID Number: 20-1752680001

Date of Initial License for Current Owners: 1/1/05

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 _____	

In the event there are further questions about this report, please contact:
Name: Gary F. Eye **Telephone Number:** (716) 662-4955, ext 392

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Gary F. Eye</u>	
	(Title) <u>Senior VP of Finance of Tara Cares</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Granite Nsg & Rehab Center# 0046904 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	<u>12</u>	Skilled (SNF)	<u>12</u>	<u>4,380</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>74</u>	Intermediate (ICF)	<u>74</u>	<u>27,010</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>86</u>	TOTALS	<u>86</u>	<u>31,390</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>594</u>		<u>3,449</u>	<u>4,043</u>	8
9	SNF/PED					9
10	ICF	<u>15,533</u>	<u>6,113</u>	<u>1,395</u>	<u>23,041</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,127</u>	<u>6,113</u>	<u>4,844</u>	<u>27,084</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.28%

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)

NoneF. 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 1/1/05

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 12 and days of care provided 3,449Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 1/1 to 12/31/06 Fiscal Year: 1/1 to 12/31/06

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	132,871	12,667	1,961	147,499		147,499	(1,601)	145,898			1
2	Food Purchase		122,955		122,955		122,955	(316)	122,639			2
3	Housekeeping	56,574	16,443		73,017		73,017	(578)	72,439			3
4	Laundry	51,904	9,995		61,899		61,899		61,899			4
5	Heat and Other Utilities			77,686	77,686		77,686		77,686			5
6	Maintenance	29,111	16,792	91,453	137,356		137,356	(16,708)	120,648			6
7	Other (specify):* see trial balance			6,215	6,215		6,215		6,215			7
8	TOTAL General Services	270,460	178,852	177,315	626,627		626,627	(19,203)	607,424			8
	B. Health Care and Programs											
9	Medical Director			10,400	10,400		10,400	(800)	9,600			9
10	Nursing and Medical Records	1,006,058	77,726	42,222	1,126,006		1,126,006	1,566	1,127,572			10
10a	Therapy		2,906	402,768	405,674		405,674	220,556	626,230			10a
11	Activities	30,205	3,474	1,874	35,553		35,553	(263)	35,290			11
12	Social Services	30,138	23	1,737	31,898		31,898		31,898			12
13	CNA Training											13
14	Program Transportation			1,966	1,966		1,966		1,966			14
15	Other (specify):* see trial balance			50,492	50,492		50,492	(1,498)	48,994			15
16	TOTAL Health Care and Programs	1,066,401	84,129	511,459	1,661,989		1,661,989	219,561	1,881,550			16
	C. General Administration											
17	Administrative	146,674		174,696	321,370		321,370	7,949	329,319			17
18	Directors Fees											18
19	Professional Services			19,061	19,061		19,061		19,061			19
20	Dues, Fees, Subscriptions & Promotions			59,515	59,515		59,515	(5,582)	53,933			20
21	Clerical & General Office Expenses	3,950	28,839	33,214	66,003		66,003	(8,964)	57,039			21
22	Employee Benefits & Payroll Taxes			523,383	523,383		523,383	(4,563)	518,820			22
23	Inservice Training & Education											23
24	Travel and Seminar			34,190	34,190		34,190	(1,764)	32,426			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			140,229	140,229		140,229	(2,600)	137,629			26
27	Other (specify):* see trial balance			154,730	154,730		154,730	(137,353)	17,377			27
28	TOTAL General Administration	150,624	28,839	1,139,018	1,318,481		1,318,481	(152,877)	1,165,604			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,487,485	291,820	1,827,792	3,607,097		3,607,097	47,481	3,654,578			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: 1/1/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			41,808	41,808		41,808	4,650	46,458			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,959	182,959		182,959	(33,723)	149,236			32
33	Real Estate Taxes			75,205	75,205		75,205		75,205			33
34	Rent-Facility & Grounds			74,027	74,027		74,027		74,027			34
35	Rent-Equipment & Vehicles			16,993	16,993		16,993		16,993			35
36	Other (specify):* Amtz Customer Rights			656	656		656		656			36
37	TOTAL Ownership			391,648	391,648		391,648	(29,073)	362,575			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,179	1,179		1,179		1,179			39
40	Barber and Beauty Shops			11,916	11,916		11,916		11,916			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			90,901	90,901		90,901	(18,113)	72,788			43
44	TOTAL Special Cost Centers			151,081	151,081		151,081	(18,113)	132,968			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,487,485	291,820	2,370,521	4,149,826		4,149,826	295	4,150,121			45

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

Facility Name & ID Number Granite Nsg & Rehab Center

0046904

Report Period Beginning: 1/1/06

Ending: 12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(187)	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	(33,723)	32		10
11	Discounts, Allowances, Rebates & Refunds	(70)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(583)	30		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,580)	21		18
19	Entertainment	(53)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,273)	27		24
25	Fund Raising, Advertising and Promotional	(5,582)	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	(44,846)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (231,026)		\$	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)	231,321	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 231,321		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 295		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					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
						52

Granite Nsg & Rehab Center

ID# 0046904

Report Period Beginning: 1/1/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non Allowable Prior Year Costs	\$ (17,097)	43	1
2	Remove Non Allowable RX-MD non formular cost	(515)	43	2
3	Remove Employee Recognition Program >\$25/EE	(2,073)	22	3
4	Offset Interco Sold Services Revenue	(263)	11	4
5	Offset Interco Sold Services Revenue	(742)	17	5
6	Offset Interco Sold Services Revenue	(120)	17	6
7	Offset Interco Sold Services Revenue	(578)	3	7
8	Offset Interco Sold Services Revenue	(60)	10	8
9	Offset Interco Sold Services Revenue	(483)	10	9
10	Offset Interco Sold Services Revenue	(629)	22	10
11	Remove Interco Purchased Services Mark Up	(248)	17	11
12	Remove Interco Purchased Services Mark Up	(135)	1	12
13	Remove Interco Purchased Services Mark Up	(600)	6	13
14	Remove Interco Purchased Services Mark Up	(1,466)	1	14
15	Capitalize Repairs & Maintenance for Medicaid	(16,108)	6	15
16	Amortization of LHI Capitalized for Medicaid	5,233	30	16
17	Remove Restricted Work.Comp.Interest Income	(1,097)	22	17
18	Remove Non Allowable Visa Costs	(851)	24	18
19	Remove Non Allowable Podiatry-Physicians Fees	(41)	43	19
20	Remove Non Allowable Admins-Other Supplies	(314)	21	20
21	Remove Non Allowable Insurance Costs	(2,600)	26	21
22	Remove Non Allowable Contributions	(80)	27	22
23	Remove Non Allowable Outpatient Svc-Consol	(94)	43	23
24	Remove Non Allowable Med Dir-Physician Fees	(800)	9	24
25	Remove Non Allowable Visa Costs	(457)	22	25
26	Remove Non Allowable IV Prescription Drugs	(270)	43	26
27	Remove Non Allowable Nrsng Admin-Purch Svcs	(1,498)	15	27
28	Remove Non Allowable Plant Op-Lodging	(860)	24	28
29				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	(44,846)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nsg & Rehab Center

0046904

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,601)	0	0	0	0	0	0	0	0	0	0	(1,601)	1
2	Food Purchase	(316)	0	0	0	0	0	0	0	0	0	0	(316)	2
3	Housekeeping	(578)	0	0	0	0	0	0	0	0	0	0	(578)	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	(16,708)	0	0	0	0	0	0	0	0	0	0	(16,708)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(19,203)	0	0	0	0	0	0	0	0	0	0	(19,203)	8
	B. Health Care and Programs													
9	Medical Director	(800)	0	0	0	0	0	0	0	0	0	0	(800)	9
10	Nursing and Medical Records	(543)	2,109	0	0	0	0	0	0	0	0	0	1,566	10
10a	Therapy	0	220,556	0	0	0	0	0	0	0	0	0	220,556	10a
11	Activities	(263)	0	0	0	0	0	0	0	0	0	0	(263)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,498)	0	0	0	0	0	0	0	0	0	0	(1,498)	15
16	TOTAL Health Care and Programs	(3,104)	222,665	0	219,561	16								
	C. General Administration													
17	Administrative	(1,110)	9,059	0	0	0	0	0	0	0	0	0	7,949	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,582)	0	0	0	0	0	0	0	0	0	0	(5,582)	20
21	Clerical & General Office Expenses	(8,964)	0	0	0	0	0	0	0	0	0	0	(8,964)	21
22	Employee Benefits & Payroll Taxes	(4,256)	(307)	0	0	0	0	0	0	0	0	0	(4,563)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,764)	0	0	0	0	0	0	0	0	0	0	(1,764)	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):*	(137,353)	0	0	0	0	0	0	0	0	0	0	(137,353)	27
28	TOTAL General Administration	(161,629)	8,752	0	(152,877)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(183,936)	231,417	0	47,481	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nsg & Rehab Center

0046904

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,650	0	0	0	0	0	0	0	0	0	0	4,650	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(33,723)	0	0	0	0	0	0	0	0	0	0	(33,723)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	(29,073)	0	0	0	0	0	0	0	0	0	0	(29,073)	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):*	(18,017)	(96)	0	0	0	0	0	0	0	0	0	(18,113)	43
44	TOTAL Special Cost Centers	(18,017)	(96)	0	(18,113)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(231,026)	231,321	0	295	45								

Facility Name & ID Number Granite Nsg & Rehab Center

0046904

Report Period Beginning:

1/1/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See attached schedule detailing information for Schedule VII, Section A				

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	\$ 174,696	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 183,755	\$ 9,059	1
2	V	34 Sublease Building & Equip	74,027	Tara Midwest, LLC	0.00%	74,027		2
3	V	10 Pharmacy Consulting Services	10,860	Tara Pharmacy SE, LLC	0.00%	12,969	2,109	3
4	V	43 Flu Vaccines for Residents	729	Tara Pharmacy SE, LLC	0.00%	633	(96)	4
5	V	22 Flu Vaccines for Employees	2,311	Tara Pharmacy SE, LLC	0.00%	2,004	(307)	5
6	V	10a Physical Therapy Fees	152,484	Tara Therapy, LLC	0.00%	291,988	139,504	6
7	V	10a Occupational Therapy Fees	201,000	Tara Therapy, LLC	0.00%	225,280	24,280	7
8	V	10a Speech Therapy Fees	49,284	Tara Therapy, LLC	0.00%	106,056	56,772	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 665,391			\$ 896,712	\$ * 231,321	14

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	Donald T. Denz	Co-CEO and CFO	See attachment	45.00	***	0.74	1.85	Finance	\$ 4,105	17	1
2	Norbert A. Bennett	Co-CEO	See attachment	45.00	***	0.74	1.85	Operations	4,105	17	2
3	Gail M. Polanski	SVP Quality	See attachment	10.00	***	0.74	1.85	Quality Assuranc	5,432	17	3
4		Assurance									4
5	Suzette Wilson	Vice President	See attachment	0.00	***	0.74	1.85	Admissions	3,430	17	5
6											6
7											7
8	*** Compensation paid only through Support Office and allocated share reported in column 7.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,072		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:

1/1/06

Ending: 12/31/06

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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	<u>17</u>	<u>Administrative Services Costs</u>	<u>Days</u>		\$	\$		\$	1
2									2
3									3
4									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	Health Care REIT, Inc.		X	Acquisition of Operating Rights		12/31/04	\$ 207,900	\$ 207,900	6/30/2018	5.7250	\$ 11,928	1								
2												2								
3	Health Care REIT, Inc.		X	Capital Improvements		1/23/06	1,927,451	1,581,583	1/23/2010	9.1300	158,103	3								
4	Health Care REIT, Inc.		X	Capital Improvements		8/16/06	6,344	6,344	8/31/09	9.3800	226	4								
5												5								
Working Capital																				
6	Health Care REIT, Inc.		X	Working Capital		12/31/04	114,699	114,699	12/31/2007		12,702	6								
7										11.4100		7								
8												8								
9	TOTAL Facility Related						\$ 2,256,394	\$ 1,910,526			\$ 182,959	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,256,394	\$ 1,910,526			\$ 182,959	15								

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

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

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

Facility Name & ID Number **Granite Nsg & Rehab Center**

0046904 Report Period Beginning: **1/1/06**

Ending: **12/31/06**

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 2005 report.		\$	59,860	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.)		\$	65,885	2
3. Under or (over) accrual (line 2 minus line 1).		\$	6,025	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	69,180	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.		\$	75,205	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	47,273	8	
	2002	51,851	9	
	2003	57,008	10	
	2004	63,161	11	
	2005	65,885	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Granite Nsg & Rehab Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046904

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

TELEPHONE (716) 662-4955, ext 392 FAX #: (716) 662-4468

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>22-2-20-07-08-201-010</u>	<u>3500 Century Dr Lot 1</u>	\$ <u>60,863.74</u>	\$ <u>60,863.74</u>
2. <u>22-2-20-07-08-201-011</u>	<u>3500 Century Dr Lot 2</u>	\$ <u>5,021.50</u>	\$ <u>5,021.50</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>65,885.24</u>	\$ <u>65,885.24</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

1/1/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,942 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).

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: 269,573 2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: 53,914 4. Dates Incurred: Prior to January 1, 2005

Nature of Costs: Includes capitalized pre-opening salaries, fringe benefits and other costs incurred prior to 1/01/05 and allocated via related organization.
(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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Granite Nsg & Rehab Center

0046904

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Plumbing and Mechanical repairs capitalized for Medicaid		2005	7,645	2,548	3	2,548		3,822	9
10		Paint - Kitchen		2006	4,500	450	5	450		450	10
11		Paint Center of Building		2006	37,004	3700	5	3700		3700	11
12		Window Treatment		2006	5,089	509	5	509		509	12
13		20 Ton HVAC Unit		2006	20,160	1008	10	1008		1008	13
14		Sprinkler System		2006	232,098	9671	12	9671		9671	14
15		Emergency Lighting		2006	2,033	85	12	85		85	15
16		Weatherproof Lighting		2006	5,470	228	12	228		228	16
17		Exhaust Hood		2006	8,017	334	12	334		334	17
18		Sign		2006	800	40	10	40		40	18
19		Utility Room Cabinet		2006	2,946	123	12	123		123	19
20		Plumbing and Mechanical repairs capitalized for Medicaid		2006	16,108	2,685	3	2,685		2,685	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											34
35											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:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								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)	\$ 341,870	\$ 21,381		\$ 21,381	\$	\$ 22,655	70

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 64,359	\$ 18,355	\$ 18,355	\$		\$ 18,355	71
72	Current Year Purchases	46,282	3,242	3,242			3,242	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 110,641	\$ 21,597	\$ 21,597	\$		\$ 21,597	75

D. Vehicle Depreciation (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	Long Term Care	2006 Ford Escape	2006	\$ 24,378	\$ 4,063	\$ 4,063	\$		\$ 4,063	76
77										77
78										78
79										79
80	TOTALS			\$ 24,378	\$ 4,063	\$ 4,063	\$		\$ 4,063	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)	\$	476,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	47,041	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	47,041	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)	\$	48,315	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Boiler Project	\$ 108,748	92
93	Architect Drawings	9,072	93
94	Hand Rail Project	33,175	94
95		\$ 150,995	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.

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:	<u>1964</u>	<u>86</u>	<u>1/1/05</u>	\$ <u>74,027</u>	<u>13.5</u>	<u>1-15 yr</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		86		\$ 74,027			7

10. Effective dates of current rental agreement:

Beginning 12/31/04

Ending 6/30/18

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2007</u>	\$ <u>74,027</u>
13.	<u>12/31/2008</u>	\$ <u>74,027</u>
14.	<u>12/31/2009</u>	\$ <u>74,027</u>

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 13.5 yrs.

14,888
200,995

9. Option to Buy: YES NO Terms: 60 day notice *

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: \$ 17,010 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Granite Nsg & Rehab Center # 0046904 Report Period Beginning: 1/1/06 Ending: 12/31/06

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		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	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	Exceptional Care Program																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: 1/1/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,230,425	\$	1
2	Cash-Patient Deposits	8,313		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 192,008)	926,123		3
4	Supply Inventory (priced at cost)	5,969		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,581		6
7	Other Prepaid Expenses	196,448		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Non resident A/R (see TB)</u>	740		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,369,599	\$	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	318,118		15
16	Equipment, at Historical Cost	135,019		16
17	Accumulated Depreciation (book methods)	(41,808)		17
18	Deferred Charges	27,264		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Deposits long term</u>)	100		22
23	Other(specify): <u>Construction in progress</u>	150,995		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 589,688	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,959,287	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 353,816	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,313		28
29	Short-Term Notes Payable	602,906		29
30	Accrued Salaries Payable	119,759		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,444		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,180		32
33	Accrued Interest Payable	13,174		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Employee Benefits Payable</u>	(2,628)		36
37	<u>Accrued Expenses</u>	733,346		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,934,310	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,307,620		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)	\$ 1,307,620	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,241,930	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (282,643)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,959,287	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (166,687)	1
2	Restatements (describe):		2
3	Prior Year Adjustments	(2,547)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (169,234)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(113,409)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	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)	\$ (113,409)	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)	\$ (282,643)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Granite Nsg & Rehab Center# 0046904Report Period Beginning: 1/1/06Ending: 12/31/06**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,851,160	1
2	Discounts and Allowances for all Levels	643,060	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,494,220	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	493,093	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 493,093	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	(27)	13
14	Non-Patient Meals	187	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	634	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 794	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	35,116	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,116	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	7,703	28
28a	Prch Disc / Vending Commissions / Sold Srvcs Rev	5,491	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,194	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,036,417	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	626,627	31
32	Health Care	1,661,989	32
33	General Administration	1,318,481	33
B. Capital Expense			
34	Ownership	391,648	34
C. Ancillary Expense			
35	Special Cost Centers	103,996	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)*	\$ 4,149,826	40
41	Income before Income Taxes (line 30 minus line 40)**	(113,409)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (113,409)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 1/1/06

Ending: 12/31/06

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	2,572	2,728	\$ 71,297	\$ 26.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,357	5,633	125,735	22.32	3
4	Licensed Practical Nurses	16,119	16,781	316,561	18.86	4
5	CNAs & Orderlies	44,474	46,836	433,318	9.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,057	2,191	21,081	9.62	9
10	Activity Assistants	996	1,194	9,124	7.64	10
11	Social Service Workers	1,984	2,098	30,138	14.37	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,080	34,385	16.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,777	3,987	39,081	9.80	15
16	Dishwashers	8,085	8,534	59,405	6.96	16
17	Maintenance Workers	2,056	2,252	29,111	12.93	17
18	Housekeepers	6,400	6,707	56,574	8.44	18
19	Laundry	6,122	6,596	51,904	7.87	19
20	Administrator	1,936	2,245	70,002	31.18	20
21	Assistant Administrator					21
22	Other Administrative	1,770	1,898	37,613	19.82	22
23	Office Manager	2,047	2,216	23,183	10.46	23
24	Clerical	1,905	2,039	19,825	9.72	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 Coordinator	2,016	2,079	41,322	19.88	32
33	Other(specify) Nrsng Admin Cleric	1,641	1,928	17,826	9.25	33
34	TOTAL (lines 1 - 33)	113,354	120,022	\$ 1,487,485 *	\$ 12.39	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	21	\$ 991	1-3	35
36	Medical Director	contract	10,400	9-3	36
37	Medical Records Consultant	\$1/bed	1,036	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$10/bed	10,860	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	30	1,724	11-3	44
45	Social Service Consultant	31	1,737	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	82	\$ 26,748		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	43	\$ 1,725	10-3	50
51	Licensed Practical Nurses	767	21,612	10-3	51
52	Certified Nurse Assistants/Aides	380	6,989	10-3	52
53	TOTAL (lines 50 - 52)	1,190	\$ 30,326		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$3,162 net of non-allowable
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,320 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. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,085
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? No 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. \$ 187
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? n/a
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. 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) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? _____
Attach invoices and a summary of services for all architect and appraisal fees.