



Facility Name & ID Number Granite Nursing & Rehabilitation Center

# 0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,708	4,876	4,886	21,470	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,708	4,876	4,886	21,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.21%

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)  
none

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 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 86 and days of care provided 4,141

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 12/31/08 Fiscal Year: 1/1 to 12/31/08  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Granite Nursing & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	
	<b>A. General Services</b>											
1	Dietary	129,468	13,007	14,903	157,378		157,378	(1,430)	155,948			1
2	Food Purchase		98,433		98,433		98,433	(561)	97,872			2
3	Housekeeping	73,028	13,395		86,423		86,423	(239)	86,184			3
4	Laundry	41,398	18,514		59,912		59,912		59,912			4
5	Heat and Other Utilities			124,237	124,237		124,237		124,237			5
6	Maintenance	26,746	15,588	34,447	76,781		76,781	(23)	76,758			6
7	Other (specify):* see trial balance			7,637	7,637		7,637		7,637			7
8	<b>TOTAL General Services</b>	<b>270,640</b>	<b>158,937</b>	<b>181,224</b>	<b>610,801</b>		<b>610,801</b>	<b>(2,253)</b>	<b>608,548</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	935,331	168,626	185,232	1,289,189		1,289,189	(90,371)	1,198,818			10
10a	Therapy		134	550,649	550,783		550,783	(6,364)	544,419			10a
11	Activities	23,758	2,302	2,767	28,827		28,827		28,827			11
12	Social Services	21,654	74	4,240	25,968		25,968	(225)	25,743			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* see trial balance			30,480	30,480		30,480	(3,793)	26,687			15
16	<b>TOTAL Health Care and Programs</b>	<b>980,743</b>	<b>171,136</b>	<b>782,968</b>	<b>1,934,847</b>		<b>1,934,847</b>	<b>(100,753)</b>	<b>1,834,094</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	184,192		184,596	368,788		368,788	(26,471)	342,317			17
18	Directors Fees											18
19	Professional Services			11,303	11,303		11,303	(3,442)	7,861			19
20	Dues, Fees, Subscriptions & Promotions			34,443	34,443		34,443	(5,076)	29,367			20
21	Clerical & General Office Expenses		36,066	63,294	99,360		99,360	(49,630)	49,730			21
22	Employee Benefits & Payroll Taxes			276,979	276,979		276,979	(2,719)	274,260			22
23	Inservice Training & Education											23
24	Travel and Seminar			43,901	43,901		43,901	(2,177)	41,724			24
25	Other Admin. Staff Transportation			3,226	3,226		3,226	(392)	2,834			25
26	Insurance-Prop.Liab.Malpractice			10,197	10,197		10,197	(2,600)	7,597			26
27	Other (specify):* see trial balance			75,390	75,390		75,390	(58,286)	17,104			27
28	<b>TOTAL General Administration</b>	<b>184,192</b>	<b>36,066</b>	<b>703,329</b>	<b>923,587</b>		<b>923,587</b>	<b>(150,793)</b>	<b>772,794</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,435,575</b>	<b>366,139</b>	<b>1,667,521</b>	<b>3,469,235</b>		<b>3,469,235</b>	<b>(253,799)</b>	<b>3,215,436</b>			<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Granite Nursing & Rehabilitation Center #0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			260,453	260,453	260,453	14,614	275,067			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			206,056	206,056	206,056	(310)	205,746			32
33	Real Estate Taxes			74,330	74,330	74,330		74,330			33
34	Rent-Facility & Grounds			50,292	50,292	50,292		50,292			34
35	Rent-Equipment & Vehicles			23,144	23,144	23,144		23,144			35
36	Other (specify):* Amtz Debt Acq Costs			5,878	5,878	5,878		5,878			36
37	<b>TOTAL Ownership</b>			620,153	620,153	620,153	14,304	634,457			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops		147	524	671	671		671			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			47,214	47,214	47,214		47,214			42
43	Other (specify):* see trial balance			102,527	102,527	102,527	19,911	122,438			43
44	<b>TOTAL Special Cost Centers</b>		147	150,265	150,412	150,412	19,911	170,323			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,435,575	366,286	2,437,939	4,239,800	4,239,800	(219,584)	4,020,216			45

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

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(451)	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	(310)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,429)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(392)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,575)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(760)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,870)	27		24
25	Fund Raising, Advertising and Promotional	(5,076)	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	(112,400)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (188,373)		\$	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)	(31,211)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (31,211)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (219,584)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## Granite Nursing &amp; Rehabilitation Center

ID# 0046904

Report Period Beginning: 1/1/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Remove Non-Allowable Prior Year Costs	\$ 24,106	43 1
2	Remove Non-Allowable EE Recognition Prgm.	(1,347)	22 2
3	Offset Interco Sold Services Revenue	(239)	3 3
4	Offset Interco Sold Services Revenue	(23)	6 4
5	Offset Interco Sold Services Revenue	(1,374)	10 5
6	Offset Interco Sold Services Revenue	(637)	17 6
7	Offset Interco Sold Services Revenue	(923)	22 7
8	Remove Interco Purchased Services Mark-Up	(1,430)	1 8
9	Remove Interco Purchased Services Mark-Up	(225)	12 9
10	Remove Interco Purchased Services Mark-Up	(3,287)	15 10
11	Remove Capitalized Repairs & Maintenance	(6,100)	27 11
12	Amort/Depreciate Repair/Maint Captl. for Medicaid	14,614	30 12
13	Remove Non-Allowable Visa Costs	(111)	24 13
14	Remove Non-Allowable Admiss-Other Supplies	(9,013)	21 14
15	Remove Non-Allowable Insurance Costs	(2,600)	26 15
16	Remove Non-Allowable IV Prescription Drugs	(3,925)	43 16
17	Remove Non-Allowable Nrs. Admin-Purch Svcs	(506)	15 17
18	Remove Non-Allowable Admin-Franchise Tax	(21,592)	21 18
19	Remove Non-Allowable Acctg-Tax Fees	(2,682)	19 19
20	Offset Misc. Revenue	(21)	21 20
21	Remove Non-Allowable Admin-Purchased Svcs	(1,722)	27 21
22	Remove Non-Allowable Admiss-Meals/Ent	(1,415)	24 22
23	Remove Non-Allowable Admiss-Lodging	(651)	24 23
24	Remove Non-Allowable Contributions	(594)	27 24
25	Remove Nrs.Admin-Minor Non-Medical Equip	(90,703)	10 25
26			26
27			27
28			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	<b>Total</b>	(112,400)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Granite Nursing &amp; Rehabilitation Center

# 0046904

Report Period Beginning:

1/1/08

Ending:

12/31/08

## 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)	
	<b>A. General Services</b>													
1	Dietary	(1,430)	0	0	0	0	0	0	0	0	0	0	(1,430)	1
2	Food Purchase	(561)	0	0	0	0	0	0	0	0	0	0	(561)	2
3	Housekeeping	(239)	0	0	0	0	0	0	0	0	0	0	(239)	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	(23)	0	0	0	0	0	0	0	0	0	0	(23)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,253)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,253)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(92,077)	1,706	0	0	0	0	0	0	0	0	0	(90,371)	10
10a	Therapy	0	(6,364)	0	0	0	0	0	0	0	0	0	(6,364)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(225)	0	0	0	0	0	0	0	0	0	0	(225)	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):*	(3,793)	0	0	0	0	0	0	0	0	0	0	(3,793)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(96,095)</b>	<b>(4,658)</b>	<b>0</b>	<b>(100,753)</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	(637)	(25,834)	0	0	0	0	0	0	0	0	0	(26,471)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,442)	0	0	0	0	0	0	0	0	0	0	(3,442)	19
20	Fees, Subscriptions & Promotions	(5,076)	0	0	0	0	0	0	0	0	0	0	(5,076)	20
21	Clerical & General Office Expenses	(49,630)	0	0	0	0	0	0	0	0	0	0	(49,630)	21
22	Employee Benefits & Payroll Taxes	(2,270)	(449)	0	0	0	0	0	0	0	0	0	(2,719)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,177)	0	0	0	0	0	0	0	0	0	0	(2,177)	24
25	Other Admin. Staff Transportation	(392)	0	0	0	0	0	0	0	0	0	0	(392)	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(58,286)	0	0	0	0	0	0	0	0	0	0	(58,286)	27
28	<b>TOTAL General Administration</b>	<b>(124,510)</b>	<b>(26,283)</b>	<b>0</b>	<b>(150,793)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(222,858)</b>	<b>(30,941)</b>	<b>0</b>	<b>(253,799)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nursing & Rehabilitation Center

# 0046904

Report Period Beginning:

1//1/08

Ending:

12/31/08

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	14,614	0	0	0	0	0	0	0	0	0	0	14,614	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(310)	0	0	0	0	0	0	0	0	0	0	(310)	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	<b>TOTAL Ownership</b>	<b>14,304</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>14,304</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	20,181	(270)	0	0	0	0	0	0	0	0	0	19,911	43
44	<b>TOTAL Special Cost Centers</b>	<b>20,181</b>	<b>(270)</b>	<b>0</b>	<b>19,911</b>	<b>44</b>								
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(188,373)</b>	<b>(31,211)</b>	<b>0</b>	<b>(219,584)</b>	<b>45</b>								

Facility Name & ID Number Granite Nursing & Rehabilitation Center

# 0046904

Report Period Beginning:

1/1/08

Ending:

12/31/08

**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	\$ 184,596	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 158,762	\$ (25,834)	1
2	V	34	Sublease Building & Equip	50,292	Tara Midwest, LLC	0.00%	50,292		2
3	V	32	Capital Interest Expense	206,056	Tara Midwest, LLC	0.00%	206,056		3
4	V	10	Pharmacy Consulting Services	13,416	Tara Pharmacy SE, LLC	0.00%	15,006	1,590	4
5	V	43	Flu Vaccines for Residents	748	Tara Pharmacy SE, LLC	0.00%	478	(270)	5
6	V	22	Flu Vaccines for Employees	1,390	Tara Pharmacy SE, LLC	0.00%	941	(449)	6
7	V	10	Medical Transcription	5,676	Tara Pharmacy SE, LLC	0.00%	5,792	116	7
8	V	10a	Physical Therapy Fees	231,489	Tara Therapy, LLC	0.00%	241,490	10,001	8
9	V	10a	Occupational Therapy Fees	207,974	Tara Therapy, LLC	0.00%	188,080	(19,894)	9
10	V	10a	Speech Therapy Fees	111,186	Tara Therapy, LLC	0.00%	114,715	3,529	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,012,823			\$ 981,612	\$ * (31,211)		14

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

Facility Name & ID Number Granite Nursing & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

## 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	See attachment	See attachment	50.00	See Attachment	See Attached	See Attached	See Attached	\$ See Attachmen	17	1
2	D & N, LLC	See attachment	See attachment	50.00	See Attachment	See Attached	See Attached	See Attached	See Attachmen	17	2
3											3
4											4
5	Suzette Wilson	Vice President	See attachment	0.00	***			VP		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	\$		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 & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>\$ 331,400</u>	<u>\$ 330,524</u>	<u>21,470</u>	<u>\$ 4,964</u>	1
2	5	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>54,676</u>	<u>0</u>	<u>21,470</u>	<u>818</u>	2
3	6	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>62,381</u>	<u>1,810</u>	<u>21,470</u>	<u>934</u>	3
4	17	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>7,614,392</u>	<u>7,614,392</u>	<u>21,470</u>	<u>114,029</u>	4
5	19	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>6,890</u>	<u>0</u>	<u>21,470</u>	<u>104</u>	5
6	20	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>24,654</u>	<u>0</u>	<u>21,470</u>	<u>369</u>	6
7	21	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>322,147</u>	<u>0</u>	<u>21,470</u>	<u>4,827</u>	7
8	22	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>1,019,506</u>	<u>0</u>	<u>21,470</u>	<u>15,268</u>	8
9	24	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>289,109</u>	<u>0</u>	<u>21,470</u>	<u>4,329</u>	9
10	25	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>347,091</u>	<u>0</u>	<u>21,470</u>	<u>5,198</u>	10
11	26	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>5,811</u>	<u>0</u>	<u>21,470</u>	<u>87</u>	11
12	27	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>77,338</u>	<u>0</u>	<u>21,470</u>	<u>1,160</u>	12
13	30	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>281,539</u>	<u>0</u>	<u>21,470</u>	<u>4,216</u>	13
14	31	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>35,842</u>	<u>0</u>	<u>21,470</u>	<u>537</u>	14
15	33	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>26,254</u>	<u>0</u>	<u>21,470</u>	<u>393</u>	15
16	34	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>93,028</u>	<u>0</u>	<u>21,470</u>	<u>1,393</u>	16
17	35	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>9,111</u>	<u>0</u>	<u>21,470</u>	<u>136</u>	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					<u>\$ 10,601,169</u>	<u>\$ 7,946,726</u>		<u>\$ 158,762</u>	25

Facility Name & ID Number Granite Nursing & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Health Care REIT, Inc.		X	Acquisition of Operating Rights	Interst only until Maturity	12/31/04	\$ 207,900	\$ 207,900	6/30/2018	5.7500	\$ 11,928	1								
2												2								
3	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	1/23/06	1,927,451	638,251	1/23/2010	9.6300	83,374	3								
4	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	8/16/06	2,000,000	1,433,707	8/31/2009	9.7800	110,754	4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 4,135,351	\$ 2,279,858			\$ 206,056	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 4,135,351	\$ 2,279,858			\$ 206,056	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Granite Nursing & Rehabilitation 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 2007 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 2007.

(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>66,133.70</u>	\$ <u>66,133.70</u>
2. <u>22-2-20-07-08-201-011</u>	<u>3500 Century Dr Lot 2</u>	\$ <u>4,652.66</u>	\$ <u>4,652.66</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>70,786.36</u>	\$ <u>70,786.36</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Granite Nursing & Rehabilitation Center

# 0046904 Report Period Beginning:

1/1/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

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).

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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: 849,335 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 1/1/05. Costs allocated via related org cost & reported on Sch V.  
(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 &amp; ID Number Granite Nursing &amp; Rehabilitation Center

# 0046904

Report Period Beginning:

1/1/08

Ending:

12/31/08

**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
	<b>Improvement Type**</b>										
9		<b>Plumbing and Mechanical repairs capitalized for Medicaid</b>		2005	7,645	1,274	3	1,274		7,645	9
10		Paint - Kitchen		2006	4,500	900	5	900		2,250	10
11		Paint Center of Building		2006	37,004	7,401	5	7,401		18,502	11
12		Window Treatment		2006	5,089	1,018	5	1,018		2,544	12
13		20 Ton HVAC Unit		2006	20,160	2,016	10	2,016		5,040	13
14		Sprinkler System		2006	232,098	19,342	12	19,342		48,354	14
15		Emergency Lighting		2006	2,034	169	12	169		424	15
16		Weatherproof Lighting		2006	5,470	456	12	456		1,140	16
17		Exhaust Hood		2006	8,017	668	12	668		1,670	17
18		Sign		2006	800	80	10	80		200	18
19		Utility Room Cabinet		2006	2,946	246	12	246		614	19
20		<b>Plumbing and Mechanical repairs capitalized for Medicaid</b>		2006	16,108	5,369	3	5,369		13,424	20
21		2 Sprinkler System Heads		2007	1,578	143	11	143		215	21
22		Concrete Sidewalk		2007	2,470	247	10	247		371	22
23		Mag Locks and Key Pads		2007	2,604	260	10	260		391	23
24		Physical Therapy Addition		2007	431,389	39,217	11	39,217		58,826	24
25											25
26		<b>Plumbing and Mechanical repairs capitalized for Medicaid</b>		2007	20,861	6,953	3	6,953		10,430	26
27		Generator		2008	146,483	14,648	5	14,648		14,648	27
28		Mechanical/Electrical Systems Upgrade & Significant Bldg Improvements		2008	1,623,449	81,173	10	81,173		81,173	28
29		Dry Pendants		2008	3,020	151	10	151		151	29
30		Window Treatments		2008	30,741	3,074	5	3,074		3,074	30
31		Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2		2008	882,074	44,104	10	44,104		44,104	31
32		Facility Sign		2008	12,836	642	10	642		642	32
33		Roof		2008	132,870	6,644	10	6,644		6,644	33
34		<b>Physical Therapy Costs capitalized for Medicaid</b>		2008	6,100	1,017	3	1,017		1,017	34
35		<b>Depreciation on Asset#57 Burnisher Disposed on 5/31/08</b>		2008		132		132			35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Granite Nursing & Rehabilitation Center

# 0046904

Report Period Beginning:

1/1/08

Ending:

12/31/08

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)	\$ 3,638,346	\$ 237,344		\$ 237,344	\$	\$ 323,493	70

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

Facility Name & ID Number Granite Nursing & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	\$ 144,686	\$ 23,142	\$ 23,142	\$		\$ 65,405	71
72	Current Year Purchases	116,843	6,455	6,455			6,455	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 261,529	\$ 29,597	\$ 29,597	\$		\$ 71,860	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	\$ 8,126	\$ 8,126	\$	3	\$ 20,315	76
77										77
78										78
79										79
80	TOTALS			\$ 24,378	\$ 8,126	\$ 8,126	\$		\$ 20,315	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)	\$ 3,924,253	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 275,067	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 275,067	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)	\$ 415,668	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		\$	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.

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>50,292</u>	<u>13.5</u>	<u>1-15 yr.</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>86</b>		\$ <b>50,292</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 06/30/2018

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2009</u>	\$ <u>50,292</u>
13.	<u>12/31/2010</u>	\$ <u>50,292</u>
14.	<u>12/31/2011</u>	\$ <u>50,292</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 \_\_\_\_\_.

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: \$ 24,151 Description: See separate schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See separate schedule</u>		\$ _____	\$ <u>50</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <b>50</b>	<b>21</b>

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

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

- (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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

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

Facility Name & ID Number Granite Nursing & Rehabilitation Center # 0046904 Report Period Beginning: 1/1/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (832,403)	\$	1
2	Cash-Patient Deposits	29,243		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	864,314		3
4	Supply Inventory (priced at )	7,761		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,675		6
7	Other Prepaid Expenses	24,062		7
8	Accounts Receivable (owners or related parties)	(1,422,975)		8
9	Other(specify): <u>Non resident A/R (see TB)</u>	367		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (1,327,956)	\$	10
<b>B. Long-Term Assets</b>				
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	3,587,631		15
16	Equipment, at Historical Cost	285,907		16
17	Accumulated Depreciation (book methods)	(383,149)		17
18	Deferred Charges	5,760		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(37)		21
22	Other Long-Term Assets (spe <u>Deposits long term</u> )	100		22
23	Other(specify): <u>Construction in progress</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,496,212	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,168,256	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 61,951	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,243		28
29	Short-Term Notes Payable	1,761,142		29
30	Accrued Salaries Payable	142,494		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,261		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,330		32
33	Accrued Interest Payable	16,807		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Employee Benefits Payable</u>	(6,199)		36
37	<u>Accrued Expenses</u>	713,600		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,819,629	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	518,717		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 518,717	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,338,346	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,170,090)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,168,256	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (616,414)	1
2	Restatements (describe):		2
3	Prior Period Adjustment Operating Rights Impairment	(157,601)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (774,015)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(396,075)	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)	\$ (396,075)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (1,170,090)	24 *

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

Facility Name & ID Number Granite Nursing & Rehabilitation Center# 0046904Report Period Beginning: 1/1/08Ending: 12/31/08**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,370,200	1
2	Discounts and Allowances for all Levels	1,182,231	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,552,431	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,531	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 283,531	8
<b>C. Other Operating Revenue</b>			
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	451	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 500	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	428	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 428	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Prior Year Net Revenue</b>	1,023	28
28a	<b>Prch Disc / Vending Commissions / Sold Srvc Rev</b>	5,812	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,835	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,843,725	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	610,801	31
32	Health Care	1,934,847	32
33	General Administration	923,587	33
<b>B. Capital Expense</b>			
34	Ownership	620,153	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	103,198	35
36	Provider Participation Fee	47,214	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,239,800	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(396,075)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (396,075)	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 Nursing & Rehabilitation Center

# 0046904

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,845	1,953	\$ 69,423	\$ 35.55	1
2	Assistant Director of Nursing	148	172	4,759	27.67	2
3	Registered Nurses	4,452	4,667	109,476	23.46	3
4	Licensed Practical Nurses	14,495	15,183	309,752	20.40	4
5	CNAs & Orderlies	35,615	37,386	367,779	9.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,717	1,861	17,181	9.23	9
10	Activity Assistants	678	738	6,578	8.91	10
11	Social Service Workers	1,842	1,927	21,654	11.24	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,257	37,719	16.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,746	5,848	50,812	8.69	15
16	Dishwashers	5,138	5,459	40,937	7.50	16
17	Maintenance Workers	1,970	2,195	26,746	12.18	17
18	Housekeepers	6,959	7,544	73,028	9.68	18
19	Laundry	4,337	4,749	41,398	8.72	19
20	Administrator	2,136	2,304	92,210	40.02	20
21	Assistant Administrator					21
22	Other Administrative	1,488	1,520	35,151	23.13	22
23	Office Manager	2,120	2,160	37,556	17.39	23
24	Clerical	1,642	1,812	19,275	10.64	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 Coordinator	3,265	3,496	55,546	15.89	32
33	Other(specify) Nrsng Admin Cleric	1,611	1,731	18,595	10.74	33
34	TOTAL (lines 1 - 33)	99,252	104,962	\$ 1,435,575 *	\$ 13.68	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	0	\$ 0	1-3 35
36	Medical Director	110	9,600	9-3 36
37	Medical Records Consultant	53	3,209	10-3 37
38	Nurse Consultant	0	0	38
39	Pharmacist Consultant	\$13/bed	13,416	10-3 39
40	Physical Therapy Consultant	0	0	40
41	Occupational Therapy Consultant	0	0	41
42	Respiratory Therapy Consultant	0	0	42
43	Speech Therapy Consultant	0	0	43
44	Activity Consultant	36	2,262	11-3 44
45	Social Service Consultant	36	2,262	12-3 45
46	Other(specify)	0	0	46
47	Medical Records Preparation	\$5.50/bed	5,676	10-3 47
48				48
49	TOTAL (lines 35 - 48)	235	\$ 36,425	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,300	\$ 80,993	10-3 50
51	Licensed Practical Nurses	478	15,633	10-3 51
52	Certified Nurse Assistants/Aides	2,809	57,877	10-3 52
53	TOTAL (lines 50 - 52)	4,587	\$ 154,503	53





Facility Name &amp; ID Number Granite Nursing &amp; Rehabilitation Center

## 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 \$1,511 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. \$ 15,914 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. \$ 47,214  
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. \$ 451
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number Granite Nursing & Rehabilitation Center

# 0046904

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$	\$		\$	\$	\$	\$	1
2	<u>Improvements Made by Landlord (covered by rent at outset</u>								
3	<u>of Change of Ownership)</u>								
4									4
5	Aspire Telephone System	2005	7,542	754	10	754		2,640	5
6	Garage Door	2005	536	54	10	54		188	6
7	Ductwork Removal & Installation	2005	10,635	818	13	818		2,863	7
8	Replace Plumbing & Garbage Disposal	2005	6,767	521	13	521		1,822	8
9	Exhaust Fan - Laundry Area	2005	855	86	10	86		299	9
10	Doors (6)	2005	6,800	523	13	523		1,831	10
11	Air Conditioning Units (3)	2005	3,294	659	5	659		2,306	11
12	Carpeting	2005	587	117	5	117		411	12
13	Roof Repairs - New Gutters and Facia	2005	4,850	485	10	485		1,698	13
14	Fire Damper	2005	1,250	125	10	125		438	14
15	Pave Walkway	2005	5,714	714	8	714		2,500	15
16	Replace 140' Sewer & Floor	2005	39,530	3,041	13	3,041		10,643	16
17	Floor Replacement Cost @ 6/30/06	2006	17,434	1,320	10	1,320		3,299	17
18	Floor Replacement Addl Cost Post 6/30/06	2006	(4,237)					6,597	18
19	Walk-in Cooler / Freezer	2006	31,667	2,639	12	2,639		1,923	19
20	Paint Exterior of Facility	2006	3,847	769	5	769		3,854	20
21	Plumbing Install Sinks (2)	2006	18,500	1,542	12	1,542		819	21
22	Carpeting	2006	1,639	328	5	328			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	\$ 5,278		\$ 14,494	\$ 0	\$ 44,130	34

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