

Facility Name & ID Number Granite Nursing and Rehabilitation Center

0046904 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 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	14,838	7,755	5,923	28,516	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,838	7,755	5,923	28,516	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.84%

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 4,805

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 12/31/09 Fiscal Year: 1/1 to 12/31/09

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	141,855	18,839	11,895	172,589		172,589	(2,281)	170,308		1
2	Food Purchase		153,881		153,881		153,881	(327)	153,554		2
3	Housekeeping	119,156	14,813		133,969		133,969		133,969		3
4	Laundry	32,617	8,823		41,440		41,440		41,440		4
5	Heat and Other Utilities			115,162	115,162		115,162		115,162		5
6	Maintenance	25,337	10,951	46,105	82,393		82,393	(6,428)	75,965		6
7	Other (specify):* see trial balance			14,037	14,037		14,037		14,037		7
8	TOTAL General Services	318,965	207,307	187,199	713,471		713,471	(9,036)	704,435		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,405,909	93,161	85,504	1,584,574		1,584,574	9,197	1,593,771		10
10a	Therapy		1,342	1,117,586	1,118,928		1,118,928	(224,516)	894,412		10a
11	Activities	32,253	831	2,642	35,726		35,726		35,726		11
12	Social Services	27,918	1,408	1,649	30,975		30,975		30,975		12
13	CNA Training										13
14	Program Transportation			1,958	1,958		1,958		1,958		14
15	Other (specify):* see trial balance			25,719	25,719		25,719	(5,739)	19,980		15
16	TOTAL Health Care and Programs	1,466,080	96,742	1,244,658	2,807,480		2,807,480	(221,058)	2,586,422		16
	C. General Administration										
17	Administrative	204,724		265,752	470,476		470,476	(36,090)	434,386		17
18	Directors Fees										18
19	Professional Services			10,801	10,801		10,801	(6,271)	4,530		19
20	Dues, Fees, Subscriptions & Promotions			24,862	24,862		24,862	(6,380)	18,482		20
21	Clerical & General Office Expenses		38,936	54,599	93,535		93,535	(36,897)	56,638		21
22	Employee Benefits & Payroll Taxes			391,800	391,800		391,800	(2,241)	389,559		22
23	Inservice Training & Education										23
24	Travel and Seminar			32,133	32,133		32,133	(66)	32,067		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			139,892	139,892		139,892	(2,600)	137,292		26
27	Other (specify):* see trial balance			91,893	91,893		91,893	(71,957)	19,936		27
28	TOTAL General Administration	204,724	38,936	1,011,732	1,255,392		1,255,392	(162,502)	1,092,890		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,989,769	342,985	2,443,589	4,776,343		4,776,343	(392,596)	4,383,747		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			416,849	416,849	416,849	12,727	429,576				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,153	76,153	76,153	(2,956)	73,197				32
33	Real Estate Taxes			83,640	83,640	83,640	5,333	88,973				33
34	Rent-Facility & Grounds			79,345	79,345	79,345		79,345				34
35	Rent-Equipment & Vehicles			40,219	40,219	40,219		40,219				35
36	Other (specify):* Amtz Debt Acq Costs			5,760	5,760	5,760		5,760				36
37	TOTAL Ownership			701,966	701,966	701,966	15,104	717,070				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			682	682	682		682				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			191,703	191,703	191,703	(40,333)	151,370				43
44	TOTAL Special Cost Centers			239,470	239,470	239,470	(40,333)	199,137				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,989,769	342,985	3,385,025	5,717,779	5,717,779	(417,825)	5,299,954				45

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center

0046904

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	(142)	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	(442)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,629)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(185)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	363	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,917)	27		24
25	Fund Raising, Advertising and Promotional	(6,380)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(77,150)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (154,482)		\$	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)	(263,343)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (263,343)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (417,825)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Granite Nursing and Rehabilitation Center

ID# 0046904

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Prior Year Costs	\$ (21,482)	43	1
2	Remove Non-allowable EE Recognition Progam	(788)	22	2
3	Remove Non-allowable Employee Benefits	(153)	22	3
4	Offset Interco Sold Services Revenue	(97)	6	4
5	Offset Interco Sold Services Revenue	(470)	17	5
6	Offset Interco Sold Services Revenue	(230)	22	6
7	Remove Interco Purchased Services Mark-up	(86)	27	7
8	Remove Interco Purchased Services Mark-up	(825)	15	8
9	Remove Interco Purchased Services Mark-up	(2,281)	1	9
10	Remove Non-allowable Visa Costs	(66)	24	10
11	Remove Non-allowable Visa Costs	(15)	22	11
12	Remove Capitalized Repairs & Maintenance	(6,331)	6	12
13	Amort/Depreciate Repair/Maint Captl. for Medicaid	12,727	30	13
14	Remove Non-allowable Admiss-Other Supplies	(7,026)	21	14
15	Remove Non-allowable Insurance Costs	(2,600)	26	15
16	Remove Non-allowable IV Prescription Drugs	(6,240)	43	16
17	Remove Non-allowable Nrs Admin-Purch Svcs	(4,914)	15	17
18	Remove Non-allowable Admin. Franchise Tax	(26,663)	21	18
19	Remove Non-allowable Acctg- Tax Fees	(6,634)	19	19
20	Remove Non-allowable Admin.- Other Fees	(54)	27	20
21	Remove Non-allowable Admin- Purchased Srvc	(2,931)	27	21
22	Remove Non-allowable Contributions	(969)	27	22
23	Offset Misc. Revenue	(579)	21	23
24	Offset Misc. Revenue - interest charged on A/R	(2,514)	32	24
25	Remove Non-allowable RN Agency Fees	(1,262)	10	25
26	Remove Real Estate Tax Under/(Over) Accrual	5,333	33	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	Total		(77,150)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Granite Nursing and Rehabilitation Center

0046904 Report Period Beginning:

1/1/09

Ending: 12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(2,281)	0	0	0	0	0	0	0	0	0	0	(2,281)	1
2	Food Purchase	(327)	0	0	0	0	0	0	0	0	0	0	(327)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(6,428)	0	0	0	0	0	0	0	0	0	0	(6,428)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,036)	0	0	0	0	0	0	0	0	0	0	(9,036)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,262)	10,459	0	0	0	0	0	0	0	0	0	9,197	10
10a	Therapy	0	(224,516)	0	0	0	0	0	0	0	0	0	(224,516)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(5,739)	0	0	0	0	0	0	0	0	0	0	(5,739)	15
16	TOTAL Health Care and Programs	(7,001)	(214,057)	0	(221,058)	16								
	C. General Administration													
17	Administrative	(470)	(35,620)	0	0	0	0	0	0	0	0	0	(36,090)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,271)	0	0	0	0	0	0	0	0	0	0	(6,271)	19
20	Fees, Subscriptions & Promotions	(6,380)	0	0	0	0	0	0	0	0	0	0	(6,380)	20
21	Clerical & General Office Expenses	(36,897)	0	0	0	0	0	0	0	0	0	0	(36,897)	21
22	Employee Benefits & Payroll Taxes	(1,186)	(1,055)	0	0	0	0	0	0	0	0	0	(2,241)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(66)	0	0	0	0	0	0	0	0	0	0	(66)	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):*	(71,957)	0	0	0	0	0	0	0	0	0	0	(71,957)	27
28	TOTAL General Administration	(125,827)	(36,675)	0	(162,502)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(141,864)	(250,732)	0	(392,596)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Granite Nursing and Rehabilitation Center # 0046904 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	12,727	0	0	0	0	0	0	0	0	0	0	12,727	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,956)	0	0	0	0	0	0	0	0	0	0	(2,956)	32
33	Real Estate Taxes	5,333	0	0	0	0	0	0	0	0	0	0	5,333	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	15,104	0	0	0	0	0	0	0	0	0	0	15,104	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):*	(27,722)	(12,611)	0	0	0	0	0	0	0	0	0	(40,333)	43
44	TOTAL Special Cost Centers	(27,722)	(12,611)	0	(40,333)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(154,482)	(263,343)	0	(417,825)	45								

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Administrative Services Costs	\$ 265,752	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 230,132	\$ (35,620)	1
2	V	34 Sublease Building & Equip	79,345	Tara Midwest, LLC	0.00%	79,345		2
3	V	32 Capital Interest Expense	72,931	Tara Midwest, LLC	0.00%	72,931		3
4	V	10 Pharmacy Consulting Services	13,416	Tara Pharmacy SE, LLC	0.00%	23,309	9,893	4
5	V	43 Flu Vac/Prescription Drug- Residents	55,255	Tara Pharmacy SE, LLC	0.00%	42,644	(12,611)	5
6	V	22 Flu & Hep B Vaccine for Employees	2,824	Tara Pharmacy SE, LLC	0.00%	1,769	(1,055)	6
7	V	10 Medication Administration Records	5,676	Tara Pharmacy SE, LLC	0.00%	6,242	566	7
8	V	10a Physical Therapy Fees	428,490	Tara Therapy, LLC	0.00%	355,597	(72,893)	8
9	V	10a Occupational Therapy Fees	478,631	Tara Therapy, LLC	0.00%	358,332	(120,299)	9
10	V	10a Speech Therapy Fees	210,344	Tara Therapy, LLC	0.00%	179,020	(31,324)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,612,664			\$ 1,349,321	\$ * (263,343)	14

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

Facility Name & ID Number Granite Nursing and Rehabilitation Cente # 0046904 Report Period Beginning: 1/1/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00	0	0	0	0	\$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/Admin	0.00	***	0.68	2.03	Fin/Adm. TC	4,501	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/Admin	0.00	***	0.68	2.03	Fin/Adm. TC	4,501	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.68	2.03	VP	3,659	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										
10											10
11											11
12											12
13								TOTAL	\$ 12,661		13

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

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center # 0046904 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	1	Administrative Services Costs	Days	35	\$ 416,436	\$ 379,293	28,512	\$ 8,340	1
2	5	Administrative Services Costs	Days	35	37,610	0	28,512	753	2
3	6	Administrative Services Costs	Days	35	73,626	1,472	28,512	1,475	3
4	10	Administrative Services Costs	Days	35	2,221,486	2,101,998	28,512	44,492	4
5	17	Administrative Services Costs	Days	35	5,838,208	5,838,208	28,512	116,928	5
6	19	Administrative Services Costs	Days	35	24,843	0	28,512	498	6
7	20	Administrative Services Costs	Days	35	12,912	0	28,512	259	7
8	21	Administrative Services Costs	Days	35	300,184	0	28,512	6,012	8
9	22	Administrative Services Costs	Days	35	1,889,823	0	28,512	37,849	9
10	24	Administrative Services Costs	Days	35	149,650	0	28,512	2,997	10
11	26	Administrative Services Costs	Days	35	5,945	0	28,512	119	11
12	27	Administrative Services Costs	Days	35	111,064	0	28,512	2,224	12
13	30	Administrative Services Costs	Days	35	261,348	0	28,512	5,234	13
14	31	Administrative Services Costs	Days	35	15,588	0	28,512	312	14
15	33	Administrative Services Costs	Days	35	26,615	0	28,512	533	15
16	34	Administrative Services Costs	Days	35	103,418	0	28,512	2,071	16
17	35	Administrative Services Costs	Days	35	1,782	0	28,512	36	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 11,490,538	\$ 8,320,971		\$ 230,132	25

Facility Name & ID Number Granite Nursing and Rehabilitation Center # 0046904 Report Period Beginning: 1/1/09 Ending: 12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	Interst only	12/31/04	\$ 207,900	\$	6/1/2009	0.0575	\$ 4,970	1						
2				Rights	until Maturity							2						
3	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	1/23/06	1,927,451		6/1/2009	0.0989	20,769	3						
4	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	8/16/06	2,000,000		6/1/2009	0.0990	47,191	4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,135,351	\$			\$ 72,930	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,135,351	\$			\$ 72,930	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

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

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

1. Real Estate Tax accrual used on 2008 report.	\$	74,330	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.)	\$	79,663	2
3. Under or (over) accrual (line 2 minus line 1).	\$	5,333	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	83,640	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.	\$	88,973	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	63,161	8
	2005	65,885	9
	2006	68,397	10
	2007	70,786	11
	2008	79,663	12

2009 Real Estate Tax accrual was calculated by taking the 2008 Real Estate Tax bills divided by the 2008 assessment, the result was then multiplied by the estimated 2009 assessment. The 2009 assessment was estimated to be a 5% increase over the 2008 assessment.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>79,663.36</u>	\$ <u>79,663.36</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 and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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.**

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 659,477 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 1
 (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 Nursing and Rehabilitation Center

0046904

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Plumbing and Mechanical repairs capitalized for Medicaid		2005	7,645		3			7,645
10	Paint - Kitchen		2006	4,500	900	5	900		3,150
11	Paint Center of Building		2006	37,005	7,401	5	7,401		25,903
12	Window Treatment		2006	5,089	1,018	5	1,018		3,562
13	20 Ton HVAC Unit		2006	20,160	2,016	10	2,016		7,056
14	Sprinkler System		2006	232,098	19,342	12	19,342		67,695
15	Emergency Lighting		2006	2,034	169	12	169		593
16	Weatherproof Lighting		2006	5,470	456	12	456		1,595
17	Exhaust Hood		2006	8,017	668	12	668		2,338
18	Sign		2006	800	80	10	80		280
19	Utility Room Cabinet		2006	2,946	246	12	246		859
20	Plumbing and Mechanical repairs capitalized for Medicaid		2006	16,108	2,685	3	2,685		16,108
21	2 Sprinkler System Heads		2007	1,578	143	11	143		359
22	Concrete Sidewalk		2007	2,470	247	10	247		618
23	Mag Locks and Key Pads		2007	2,604	260	10	260		651
24	Physical Therapy Addition		2007	431,389	39,217	11	39,217		98,043
25	Plumbing and Mechanical repairs capitalized for Medicaid		2007	20,861	6,953	3	6,953		17,383
26	Generator		2007	146,483	29,297	5	29,297		43,945
27	Mechanical/Electrical Systems Upgrade & Significant Bldg Improvements		2008	1,623,449	162,345	10	162,345		243,517
28	-install wiring, plumbing, cement, Sprinkler System, ceiling, paint, paper, handrails								
29	Dry Pendants		2008	3,020	302	10	302		453
30	Window Treatments		2008	30,741	6,148	5	6,148		9,222
31	Mechanical/Electrical Systems Upgrade & Significant Bldg Imprvmnts- Stg 2		2008	882,074	88,207	10	88,207		132,311
32	-call system, wardrobes, flooring, door handles/locks, cubicle curtains/track								
33	Facility Sign		2008	12,836	1,284	10	1,284		1,925
34	Roof		2008	132,870	13,287	10	13,287		19,931
35	Physical Therapy Costs capitalized for Medicaid		2008	6,100	2,033	3	2,033		3,050
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Granite Nursing and Rehabilitation Center

0046904

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	
37	Sewer Ejector Pump	2009	\$ 9,950	\$ 553		\$ 553	\$	\$ 553	37
38	Boiler Assessment (Asset #120 Addition)	2009	11,439	636		636		636	38
39	Satellite TV Equipment	2009	12,830	713		713		713	39
40	Garage Door	2009	662	37		37		37	40
41	Generator and Carrier Air Handler rpr Capitalized for Medicaid	2009	6,331	1,055		1,055		1,055	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	Note: See additional building improvements made by property								
66	owner Healthcare REIT, Inc. on supplemental schedule								
67	included as Page 24 of the cost report.								
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,679,557	\$ 387,697		\$ 387,697	\$	\$ 711,186	70

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center # 0046904 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	\$ 246,218	\$ 34,520	\$ 34,520	\$		\$ 94,132	71
72	Current Year Purchases	58,868	5,327	5,327			5,327	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 305,086	\$ 39,847	\$ 39,847	\$		\$ 99,458	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	\$	\$ 2,032	\$ 2,032	\$	3	\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 2,032	\$ 2,032	\$		\$	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)	\$ 3,984,643	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 429,576	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 429,576	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)	\$ 810,644	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	(3) Chairs	\$ 1,106	92
93			93
94			94
95		\$ 1,106	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.

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0046904

Report Period Beginning: 1/1/09

Ending: 12/31/09

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>79,345</u>	<u>13.5</u>	<u>1-15 yr.</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		86		\$ 79,345			7

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. 12/31/2010 \$ 80,281

13. 12/31/2011 \$ 80,281

14. 12/31/2012 \$ 80,281

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: \$ 45,263 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>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center # 0046904 Report Period Beginning: 1/1/09 Ending: 12/31/09
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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

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

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

Facility Name & ID Number Granite Nursing and Rehabilitation Center

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Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (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	\$ 160,406	\$	1
2	Cash-Patient Deposits	21,536		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	528,517		3
4	Supply Inventory (priced at <u>cost</u>)	7,972		4
5	Short-Term Investments			5
6	Prepaid Insurance	946		6
7	Other Prepaid Expenses	22,779		7
8	Accounts Receivable (owners or related parties)	(2,545,388)		8
9	Other(specify): <u>Non resident A/R (see TB)</u>	1,688		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,801,544)	\$	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	3,622,512		15
16	Equipment, at Historical Cost	305,086		16
17	Accumulated Depreciation (book methods)	(765,403)		17
18	Deferred Charges	3,001		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(69)		21
22	Other Long-Term Assets (spec <u>Deposits long term</u>)	1,100		22
23	Other(specify): <u>Construction in progress</u>	1,106		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,167,333	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,365,789	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 87,949	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,139		28
29	Short-Term Notes Payable	4,495		29
30	Accrued Salaries Payable	139,130		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,836		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,640		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Employee Benefits Payable</u>	5,054		36
37	<u>Accrued Expenses</u>	717,823		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,085,066	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due To/From HC REIT</u>	501,857		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 501,857	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,586,923	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (221,134)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,365,789	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,170,090)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,170,090)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	122,618	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,071,889	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(245,551)	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)	\$ 948,956	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)	\$ (221,134)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,309,542	1
2	Discounts and Allowances for all Levels	1,676,740	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,986,282	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	840,185	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 840,185	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	142	14
15	Telephone, Television and Radio	820	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,170	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	65	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,197	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	579	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 579	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	10,154	28
28a	Prch Disc / Vending Commissions / Sold Srvcs Rev		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,154	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,840,397	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	713,471	31
32	Health Care	2,807,480	32
33	General Administration	1,255,392	33
B. Capital Expense			
34	Ownership	701,966	34
C. Ancillary Expense			
35	Special Cost Centers	192,385	35
36	Provider Participation Fee	47,085	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,717,779	40
41	Income before Income Taxes (line 30 minus line 40)**	122,618	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 122,618	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 and Rehabilitation Center

0046904

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	2,080	2,080	\$ 87,035	\$ 41.84	1
2	Assistant Director of Nursing	2,862	2,968	82,451	27.78	2
3	Registered Nurses	4,537	4,705	116,972	24.86	3
4	Licensed Practical Nurses	23,558	24,629	509,742	20.70	4
5	CNAs & Orderlies	51,355	54,145	538,306	9.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,799	1,967	21,097	10.73	9
10	Activity Assistants	1,191	1,331	11,156	8.38	10
11	Social Service Workers	1,967	2,047	27,918	13.64	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,039	31,195	15.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,620	8,045	65,957	8.20	15
16	Dishwashers	5,155	5,383	44,703	8.30	16
17	Maintenance Workers	1,962	2,098	25,337	12.08	17
18	Housekeepers	12,154	12,808	119,156	9.30	18
19	Laundry	3,342	3,619	32,617	9.01	19
20	Administrator	3,101	3,260	109,616	33.62	20
21	Assistant Administrator					21
22	Other Administrative	1,812	2,012	32,342	16.07	22
23	Office Manager	1,976	2,040	39,283	19.26	23
24	Clerical	2,098	2,290	23,483	10.25	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 C: MDS Coordinator	2,280	2,431	38,426	15.81	32
33	Other(specify) <u>Nrsg Admin Cleric</u>	2,864	3,107	32,977	10.61	33
34	TOTAL (lines 1 - 33)	135,689	143,004	\$ 1,989,769 *	\$ 13.91	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	64	\$ 3,017	1-3	35
36	Medical Director	96	9,600	9-3	36
37	Medical Records Consultant	60	3,664	10-3	37
38	Nurse Consultant	88	7,287	10-3	38
39	Pharmacist Consultant	\$13/bed	13,416	10-3	39
40	Physical Therapy Consultant			0	40
41	Occupational Therapy Consultant			0	41
42	Respiratory Therapy Consultant			0	42
43	Speech Therapy Consultant			0	43
44	Activity Consultant	31	1,932	11-3	44
45	Social Service Consultant	26	1,649	12-3	45
46	Other(specify)			0	46
47	<u>Medical Records Preparation</u>	\$5.50/bed	5,676	10-3	47
48					48
49	TOTAL (lines 35 - 48)	365	\$ 46,241		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	158	\$ 6,843	10-3	50
51	Licensed Practical Nurses	281	9,235	10-3	51
52	Certified Nurse Assistants/Aides	1,901	36,746	10-3	52
53	TOTAL (lines 50 - 52)	2,340	\$ 52,824		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Granite Nursing and Rehabilitation Center

0046904

Report Period Beginning: 1/1/09

Ending: 12/31/09

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 \$1,958 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. \$ 27,202 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. \$ 142
- (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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No personal use
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$	\$		\$	\$	\$		1
2	Improvements Made by Landlord (covered by rent at outset								2
3	of Change of Ownership)								3
4									4
5	Aspire Telephone System	2005	7,542	754	10	754		3,394	5
6	Garage Door	2005	536	54	10	54		241	6
7	Ductwork Removal & Installation	2005	10,635	818	13	818		3,681	7
8	Replace Plumbing & Garbage Disposal	2005	6,767	521	13	521		2,342	8
9	Exhaust Fan - Laundry Area	2005	855	86	10	86		385	9
10	Doors (6)	2005	6,800	523	13	523		2,354	10
11	Air Conditioning Units (3)	2005	3,294	659	5	659		2,964	11
12	Carpeting	2005	587	117	5	117		529	12
13	Roof Repairs - New Gutters and Facia	2005	4,850	485	10	485		2,183	13
14	Fire Damper	2005	1,250	125	10	125		563	14
15	Pave Walkway	2005	5,714	714	8	714		3,214	15
16	Replace 140' Sewer & Floor	2005	39,530	3,041	13	3,041		13,684	16
17	Floor Replacement Cost @ 6/30/06	2006	17,434	1,320	10	1,320		4,619	17
18	Floor Replacement Addl Cost Post 6/30/06	2006	(4,237)						18
19	Walk-in Cooler / Freezer	2006	31,667	2,639	12	2,639		9,236	19
20	Paint Exterior of Facility	2006	3,847	769	5	769		2,693	20
21	Plumbing Install Sinks (2)	2006	18,500	1,542	12	1,542		5,396	21
22	Carpeting	2006	1,639	328	5	328		1,147	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	\$ 14,494		\$ 14,494	\$ 0	\$ 58,624	34

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