FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0041186

Facility Name: Tri-State Nursing & Rehab Ctr

Address: 2500 East 175th Street (Number) Lansing (City) 60438 (Zip Code)

County: Cook

Telephone Number: (708) 474-7330 **Fax #** (708) 474-7391

HFS ID Number:

Date of Initial License for Current Owners: 09/01/1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,773	3,108	5,154	27,035	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,773	3,108	5,154	27,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.18%

D. How many bed-hold days during this year were paid by the Department?
51 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 9/1/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 4,909

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	212,107	34,979	14,810	261,896		261,896	(2,047)	259,849			1
2	Food Purchase		147,267		147,267		147,267	27	147,294			2
3	Housekeeping	132,187	22,312		154,499		154,499	(920)	153,579			3
4	Laundry	66,282	10,063		76,345		76,345	(306)	76,039			4
5	Heat and Other Utilities			98,887	98,887		98,887	629	99,516			5
6	Maintenance	52,861		100,938	153,799		153,799	5,216	159,015			6
7	Other (specify):*							1,699	1,699			7
8	**TOTAL General Services**	463,437	214,621	214,635	892,693		892,693	4,297	896,990			8
	B. Health Care and Programs											
9	Medical Director			8,250	8,250		8,250		8,250			9
10	Nursing and Medical Records	1,447,312	88,491	22,591	1,558,394		1,558,394	8,564	1,566,958			10
10a	Therapy	167,151			167,151		167,151	1,933	169,084			10a
11	Activities	98,496	10,321		108,817		108,817		108,817			11
12	Social Services	71,496	1,629	51,706	124,831		124,831	30,337	155,168			12
13	CNA Training											13
14	Program Transportation			147	147		147		147			14
15	Other (specify):*							9,613	9,613			15
16	**TOTAL Health Care and Programs**	1,784,455	100,441	82,694	1,967,590		1,967,590	50,447	2,018,037			16
	C. General Administration											
17	Administrative	85,249		8,300	93,549		93,549	(20,911)	72,638			17
18	Directors Fees											18
19	Professional Services			247,906	247,906		247,906	(186,217)	61,689			19
20	Dues, Fees, Subscriptions & Promotions			19,096	19,096		19,096	(9,606)	9,490			20
21	Clerical & General Office Expenses	63,307	16,361	252,028	331,696		331,696	(116,246)	215,450			21
22	Employee Benefits & Payroll Taxes			518,477	518,477		518,477	(27,924)	490,553			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,994	5,994		5,994	734	6,728			24
25	Other Admin. Staff Transportation			5,648	5,648		5,648	357	6,005			25
26	Insurance-Prop.Liab.Malpractice			131,465	131,465		131,465	467	131,932			26
27	Other (specify):*							14,558	14,558			27
28	**TOTAL General Administration**	148,556	16,361	1,188,914	1,353,831		1,353,831	(344,788)	1,009,043			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,396,448	331,423	1,486,243	4,214,114		4,214,114	(290,044)	3,924,070			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Tri-State Nursing & Rehab Ctr #0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,220	54,220		54,220	166,062	220,282			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,082	56,082		56,082	233,692	289,774			32
33	Real Estate Taxes			323,953	323,953		323,953	911	324,864			33
34	Rent-Facility & Grounds			309,097	309,097		309,097	(307,077)	2,020			34
35	Rent-Equipment & Vehicles			9,266	9,266		9,266	(3,126)	6,140			35
36	Other (specify):*											36
37	**TOTAL Ownership**			752,618	752,618		752,618	90,462	843,080			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		325,379	456,124	781,503		781,503	(10,417)	771,086			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):*			39,700	39,700		39,700	(39,700)				43
44	**TOTAL Special Cost Centers**		325,379	541,814	867,193		867,193	(50,117)	817,076			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,396,448	656,802	2,780,675	5,833,925		5,833,925	(249,699)	5,584,226			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	87,197	30		9
10	Interest and Other Investment Income	(41,092)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	02		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	(11,978)	21		18
19	Entertainment				19
20	Contributions	(3,137)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(178,206)	21		24
25	Fund Raising, Advertising and Promotional	(4,507)	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	(63,709)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (215,601)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(34,098)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (34,098)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (249,699)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Tri-State Nursing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (6,718)	21	1
2	Patient Clothing	(475)	10	2
3				3
4	Collection Expense	(1,211)	21	4
5	Medical Records	(20)	10	5
6	Dental Refund	(81)	10	6
7	Annual Report	(250)	20	7
8	Building Co - Bank Charges	(409)	21	8
9	Building Co - Land Trust Fees	(400)	20	9
10	Building Co - State Replacement Tax	(945)	21	10
11	Building Co - Amortization	(5,761)	36	11
12	Out of Period Legal Fees	(4,602)	19	12
13	COPE Dues	(3,137)	20	13
14	Non-Allowable Office Expense	(39,700)	43	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(63,709)		49

Tri-State Nursing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			70		(889)	2,967	(4,177)		(18)			(2,047)	1
2	Food Purchase	(169)		196									27	2
3	Housekeeping			251		28				(1,199)			(920)	3
4	Laundry									(306)			(306)	4
5	Heat and Other Utilities			571		58							629	5
6	Maintenance			1,640	3,518	58							5,216	6
7	Other (specify):*				1,285	291	123						1,699	7
8	**TOTAL General Services**	(169)		2,728	4,803	(454)	3,090	(4,177)		(1,523)			4,297	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(576)				(5,318)	18,688			(4,230)			8,564	10
10a	Therapy					1,933							1,933	10a
11	Activities													11
12	Social Services				28,954	(4,602)	5,985						30,337	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,356	2,339	2,918						9,613	15
16	**TOTAL Health Care and Programs**	(576)			33,310	(5,648)	27,591			(4,230)			50,447	16
	C. General Administration													
17	Administrative			1,162	(41,208)	19,135							(20,911)	17
18	Directors Fees													18
19	Professional Services	(4,602)		(138,492)		(43,123)							(186,217)	19
20	Fees, Subscriptions & Promotions	(11,431)	400	1,473		83				(131)			(9,606)	20
21	Clerical & General Office Expenses	(199,467)	1,354	6,884	71,469	3,514							(116,246)	21
22	Employee Benefits & Payroll Taxes				(24,869)		(3,041)			(14)			(27,924)	22
23	Inservice Training & Education													23
24	Travel and Seminar			72		662							734	24
25	Other Admin. Staff Transportation			357									357	25
26	Insurance-Prop.Liab.Malpractice			392		75							467	26
27	Other (specify):*				11,492	3,066							14,558	27
28	**TOTAL General Administration**	(215,500)	1,754	(128,152)	16,884	(16,588)	(3,041)			(145)			(344,788)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(216,245)	1,754	(125,424)	54,997	(22,690)	27,640	(4,177)		(5,899)			(290,044)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Tri-State Nursing & Rehab Ctr** **#** **0041186** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	87,197	76,346	2,119		400							166,062	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(41,092)	263,105	4,043		7,636							233,692	32
33	Real Estate Taxes			821		90							911	33
34	Rent-Facility & Grounds		(307,641)	564									(307,077)	34
35	Rent-Equipment & Vehicles			1,011								(4,137)	(3,126)	35
36	Other (specify):*	(5,761)	5,761											36
37	**TOTAL Ownership**	40,344	37,571	8,558		8,126						(4,137)	90,462	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(4,247)	(2,686)	(1,490)		(1,994)	(10,417)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(39,700)											(39,700)	43
44	**TOTAL Special Cost Centers**	(39,700)						(4,247)	(2,686)	(1,490)		(1,994)	(50,117)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(215,601)	39,325	(116,866)	54,997	(14,564)	27,640	(8,425)	(2,686)	(7,389)		(6,131)	(249,699)	45

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		See Attached		See Attached		
				Lansing Healthcare Properties		Building Co.

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. [X] 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	34	Rental Income	$ 307,641	Lansing Healthcare Properties	100.00%	$	$ (307,641)	1
2	V	33	Real Estate Taxes	335,931	Lansing Healthcare Properties	100.00%	335,931		2
3	V	32	Interest	46	Lansing Healthcare Properties	100.00%	263,151	263,105	3
4	V	21	Bank Charges		Lansing Healthcare Properties	100.00%	409	409	4
5	V	20	Land Trust Fees		Lansing Healthcare Properties	100.00%	400	400	5
6	V	21	State Replacement Tax		Lansing Healthcare Properties	100.00%	945	945	6
7	V	30	Depreciation		Lansing Healthcare Properties	100.00%	76,346	76,346	7
8	V	36	Amortization		Lansing Healthcare Properties	100.00%	5,761	5,761	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 643,618			$ 682,943	$ * 39,325	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 70	$ 70	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	196	196	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	251	251	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	571	571	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,640	1,640	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,162	1,162	20
21	V	19	Professional Fees	145,087	Extended Care Consulting, LLC	100.00%	4,845	(138,492)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,473	1,473	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,884	6,884	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	72	72	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	357	357	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	392	392	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,119	2,119	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,043	4,043	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	821	821	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	564	564	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,011	1,011	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 145,087			$ 26,471	$ * (116,866)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	3,518	$ 3,518	15
16	V	06	Maintenance (Direct)	7,313	Extended Care Consulting, LLC	100.00%	7,313		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	588	588	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	697	697	18
19	V	12	Admission (Direct)	45,721	Extended Care Consulting, LLC	100.00%	45,721	28,954	19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%	4,356	4,356	20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	4,513	(41,208)	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	54,702	54,702	22
23	V	21	Office and Clerical (Direct)	16,767	Extended Care Consulting, LLC	100.00%	16,767	16,767	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	9,895	9,895	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,597	1,597	25
26	V	22	Employee Benefits	24,869	Extended Care Consulting, LLC	100.00%		(24,869)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 94,670			$ 149,667	$ * 54,997	39

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 28	$ 28	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	58	58	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	58	58	17
18	V	19	Professional Fees	46,370	Extended Care Clinical, LLC	100.00%	3,247	(43,123)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	83	83	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	775	775	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	662	662	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	75	75	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	400	400	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	7,636	7,636	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	90	90	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	2,078	(889)	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	291	291	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	13,370	(5,318)	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	1,933	1,933	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	1,383	(4,602)	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,339	2,339	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	19,135	19,135	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	2,739	2,739	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	3,066	3,066	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 46,370			$ 59,446	$ * (14,564)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	01	Dietary Salary	$ 2,967	Extended Care Clinical, LLC	100.00%	$ 2,967	$ 2,967	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%	123	123	16
17	V	10	Nursing Salary	18,688	Extended Care Clinical, LLC	100.00%	18,688	18,688	17
18	V	12	Social Service Salary	5,985	Extended Care Clinical, LLC	100.00%	5,985	5,985	18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,918	2,918	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	3,041	Extended Care Clinical, LLC	100.00%		(3,041)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 30,681			$ 30,681	$ * 27,640	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	1	Dietary Supplies, Supplements	$ 9,404	Care Centers Health Systems, Inc.	100.00%	$ 5,226	$ (4,177)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	9,561	Care Centers Health Systems, Inc.	100.00%	5,314	(4,247)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,965			$ 10,540	$ * (8,425)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	6	R&M - Equipment	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	34,258	Reliable Medical of the Midwest, LLC	100.00%	31,572	(2,686)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 34,258			$ 31,572	$ * (2,686)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	1	Dietary	$ 271	Xcel Supply, LLC	100.00%	$ 253	$ (18)	15
16	V	3	Housekeeping	17,994	Xcel Supply, LLC	100.00%	16,794	(1,199)	16
17	V	4	Laundry	4,592	Xcel Supply, LLC	100.00%	4,286	(306)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	63,480	Xcel Supply, LLC	100.00%	59,249	(4,230)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions	1,969	Xcel Supply, LLC	100.00%	1,838	(131)	22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits	215	Xcel Supply, LLC	100.00%	200	(14)	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	22,354	Xcel Supply, LLC	100.00%	20,865	(1,490)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 110,874			$ 103,485	$ * (7,389)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 75,901	$ 75,901	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	75,901	CCS Employee Benefits Group	100.00%		(75,901)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 75,901			$ 75,901	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	35	Matrix Leasing	$ 7,698	Vent Lease LLC	100.00%	$ 3,561	$ (4,137)	15
16	V	39	Ventilator Equipment	3,710	Vent Lease LLC	100.00%	1,716	(1,994)	16
17	V	39	Other Ancillary		Vent Lease LLC	100.00%			17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,408			$ 5,277	$ * (6,131)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.19	See Attached	0.67	1.44%	Mgmt Fees	$ 8,300	17-3	1
2	Adam Vales	Owner	Clerical	4.76	See Attached	0.4	1.00%	Alloc. Salry	697	22-7	2
3	Mark Steinberg	Relative	Administrative	0	See Attached	0.98	1.78%	Al Sal/Al Fee	2,858	17-7	3
4	G. Matt Silvers	Relative	Administrative	0	See Attached	0.19	0.85%	Alloc. Salry	659	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										11
12	the IL Dept of HFS										12
13								TOTAL	$ 12,514		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 Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	27,035	$ 70	1
2	02	Food	Patient Days	1,512,273	34	10,940		27,035	196	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		27,035	251	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		27,035	571	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		27,035	1,640	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		27,035	1,162	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		27,035	4,845	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		27,035	1,473	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		27,035	6,884	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		27,035	72	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		27,035	357	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		27,035	392	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		27,035	2,119	13
14	32	Interest	Patient Days	1,512,273	34	226,162		27,035	4,043	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		27,035	821	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		27,035	564	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		27,035	1,011	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 26,471	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	27,035	3,518	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478		7,313	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		27,035	588	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607			697	4
5	12	Admission (Direct)	Direct		34	52,036	52,036		45,721	5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270			4,356	6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	27,035	4,513	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	27,035	54,702	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		16,767	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		27,035	9,895	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			1,597	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,054,827	$ 4,364,695		$ 149,667	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	27,035	$ 28	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		27,035	58	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		27,035	58	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		27,035	3,247	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		27,035	83	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		27,035	775	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		27,035	662	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		27,035	75	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		27,035	400	9
10	32	Interest	Patient Days	1,512,273	34	427,165		27,035	7,636	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		27,035	90	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	27,035	2,078	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		27,035	291	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	27,035	13,370	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	27,035	1,933	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	27,035	1,383	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		27,035	2,339	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	27,035	19,135	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	27,035	2,739	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		27,035	3,066	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 59,446	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$ 2,967	1
2	07	Emp. Ben. - General	Direct Allocation			1,662			123	2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		18,688	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		5,985	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			2,918	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 974,688	$ 868,276		$ 30,681	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 5,226	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						5,314	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 10,540	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	R&M - Equipment	Direct Allocation			$	$		$	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						31,572	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 31,572	25

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$ 253	1
2	3	Housekeeping	Direct Allocation						16,794	2
3	4	Laundry	Direct Allocation						4,286	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						59,249	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation						1,838	8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation						200	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						20,865	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 103,485	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 75,901	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 75,901	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Matrix Leasing	Direct Allocation			$	$		$ 3,561	1
2	39	Ventilator Equipment	Direct Allocation						1,716	2
3	39	Other Ancillary	Direct Allocation							3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 5,277	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cole Taylor Bank		X	Mortgage	$22,010.00	09/01/95	$ 2,620,000	$ 1,400,000			$ 82,290	1
2	Cole Taylor Bank		X	Note Payable				4,500,000			154,500	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	DIAWA Loan		X	Line of Credit							55,890	6
7	Fairfax HC Properties		X					260,000			26,361	7
8	See Supplemental Schedule										11,871	8
9	TOTAL Facility Related				$22,010.00		$ 2,620,000	$ 6,160,000			$ 330,913	9
	B. Non-Facility Related*											
10	Interest Income		X								(41,092)	10
11	Interest incom - Bldg. Co		X								(46)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (41,138)	14
15	TOTALS (line 9+line14)						$ 2,620,000	$ 6,160,000			$ 289,775	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Dowd, Bloch & Bennett		X				$	$			$ 192	8
9	Allocated From EC Consult.		X								4,043	9
10	Allocated From EC Clinical		X								7,636	10
11												11
12												12
13												13
14	TOTAL Working Capital										11,871	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.	$	254,076	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.)	$	282,877	2
3. Under or (over) accrual (line 2 minus line 1).	$	28,801	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	296,063	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.	$	324,864	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	171,934	8
2006	174,960	9
2007	181,917	10
2008	241,978	11
2009	281,966	12

2010 Accrual = $281,978 x 0.74 = $209,853

Allocated From Extended Care Consulting: $821

Allocated From Extended Care Clinical: $90

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-30-305-035-0000	Long Term Care property	$ 281,965.73	$ 281,965.73
2.	See Attached	Allocation from 2201 Main	$ 116,500.56	$ 932.14
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 398,466.29	$ 282,897.87

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? X YES _____ 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,244 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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).

Assisted Living Facility

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 84,986	1
2	Allocated From EC Consulting 2201 Main/EC Clinical 2201 Main			6,561	2
3	TOTALS			$ 91,547	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,222	1,222	18,652	9
10	Various			1996	82,791		20	4,140	4,140	60,971	10
11	Various			1997	44,854		20	2,243	2,243	30,314	11
12	Various			1998	47,497		20	2,271	2,271	31,350	12
13	Various			1999	39,389		20	1,969	1,969	23,088	13
14	Various			2000	13,995		20	700	700	7,317	14
15	Various			2001	20,621		20	1,031	1,031	9,985	15
16	Various			2002	8,353		20	642	642	6,420	16
17	Various			2003	20,578		20	1,556	1,556	11,810	17
18	Various			2004	61,438		20	5,338	5,338	40,874	18
19	Various			2005	140,855		20	13,971	13,971	73,562	19
20	Various			2006	29,295		20	2,495	2,495	17,894	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	Related Building Company (Pages 12F & 12G)		2,939,184	76,346		146,959	70,613	2,248,313	67
68	Related Party Allocations (Pages 12H & 12I)		26,440	1,801		1,801		12,603	68
69	Financial Statement Depreciation			54,218			(54,218)		69
70	TOTAL (lines 4 thru 69)		$ 3,499,721	$ 132,365		$ 186,337	$ 53,972	$ 2,593,154	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,499,721	$ 132,365		$ 186,337	$ 53,972	$ 2,593,154	1
2	New Phone System	2007	9,291		20	929	929	3,329	2
3	Painting (Transfer Expense From Home Office)	2007	9,146		20			9,146	3
4	Carpeting	2007	2,855		20	408	408	1,462	4
5	New Ceilings & Drywall	2007	10,400		20	2,080	2,080	7,453	5
6	Hvac Service	2007	4,584		20	917	917	3,285	6
7	Painting (Transfer Expense From Home Office)	2007	10,101		20	1,010	1,010	3,367	7
8	Painting (Transfer Expense From Home Office)	2007	14,393		20	1,439	1,439	4,678	8
9	New Air Compressor	2007	4,095		20	410	410	1,331	9
10	New Condensing Unit	2007	2,866		20	287	287	931	10
11	Painting (Transfer Expense From Home Office)	2007	14,349		20	1,435	1,435	4,544	11
12	Painting (Transfer Expense From Home Office)	2007	14,068		20			14,068	12
13	White Vinyl Wall Panels	2007	6,191		20			6,191	13
14	Painting (Transfer From Home Office)	2008	5,208		20			5,208	14
15	Install Fire Alarms & New Smoke Detectors	2008	3,335		20	476	476	1,429	15
16	14 Coaxial Cable Runs	2008	2,602		20	260	260	759	16
17	Painting (Transfer From Home Office)	2008	5,424		20			5,424	17
18	Painting (Transfer From Home Office)	2008	10,282		20			10,282	18
19	Painting (Transfer From Home Office)	2008	5,909		20			5,909	19
20	Painting (Transfer From Home Office)	2008	5,302		20			5,302	20
21	2 New Laundry Rooms	2008	15,900		20	1,590	1,590	3,975	21
22	New Condensing Unit	2008	3,503		20	350	350	876	22
23	Telephone System Upgrade	2008	4,299		20	430	430	1,039	23
24	Remodel Entire Shower Room	2008	10,500		20	1,050	1,050	2,363	24
25	Heating Repairs	2008	2,644		20	264	264	573	25
26	Heating Repairs	2008	11,201		20	1,120	1,120	2,427	26
27	Hvac Repairs	2009	23,976		20	2,398	2,398	3,596	27
28	Electrical Conduit Repair	2009	6,250		20	625	625	938	28
29	Plumbing Repairs	2009	5,300		20	530	530	663	29
30	Roof	2009	10,575		20	1,058	1,058	1,322	30
31	Refund Of Insurance Proceeds - Ceiling Cave In	2009	(5,392)		20	(539)	(539)	(1,078)	31
32	Landmark Adjustment - Ceiling	2009	(15,000)		20	(1,500)	(1,500)	(3,000)	32
33	Walk In Cooler	2009	3,066		20	307	307	332	33
34	TOTAL (lines 1 thru 33)		$ 3,716,944	$ 132,365		$ 203,670	$ 71,305	$ 2,701,276	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,716,944	$ 132,365		$ 203,670	$ 71,305	$ 2,701,276	1
2	Heat Sensors	2010	6,378		20	53	53	53	2
3	Piping	2010	2,565		20	128	128	128	3
4	Painting	2010	2,906		20	145	145	145	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,728,793	$ 132,365		$ 203,997	$ 71,632	$ 2,701,603	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,728,793	$ 132,365		$ 203,997	$ 71,632	$ 2,701,603	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,728,793	$ 132,365		$ 203,997	$ 71,632	$ 2,701,603	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,728,793	$ 132,365		$ 203,997	$ 71,632	$ 2,701,603	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,728,793	$ 132,365		$ 203,997	$ 71,632	$ 2,701,603	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	84 Beds	1962	2,932,035	76,346	39	146,602	70,256	2,247,896	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Heating Repairs	2008	7,149		20	357	357	417	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 2,939,184	$ 76,346		$ 146,959	$ 70,613	$ 2,248,313	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	8,144	209	39	209		1,731	3
4	Allocated From Extended Care Clinical 2201 Main	2002	897	23	39	23		191	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated From Extended Care Consulting	2007	82	4	20	4		16	10
11	Allocated From Extended Care Consulting	2009	49	2	20	2		5	11
12	Allocated From Extended Care Consulting	2010	482	24	20	24		24	12
13									13
14	Allocated From Extended Care Consulting 2201 Main	2002	6,728	615	20	615		4,310	14
15	Allocated From Extended Care Consulting 2201 Main	2003	7,928	725	20	725		5,079	15
16	Allocated From Extended Care Consulting 2201 Main	2005	394	42	20	42		184	16
17	Allocated From Extended Care Consulting 2201 Main	2009	71	4	20	4		7	17
18									18
19	Allocated From Extended Care Clinical 2201 Main	2002	741	68	20	68		475	19
20	Allocated From Extended Care Clinical 2201 Main	2003	873	80	20	80		560	20
21	Allocated From Extended Care Clinical 2201 Main	2005	43	5	20	5		20	21
22	Allocated From Extended Care Clinical 2201 Main	2009	8		20			1	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 26,440	$ 1,801		$ 1,801	$	$ 12,603	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 171,891	$ 404	$ 15,969	$ 15,565	10	$ 138,805	71
72	Current Year Purchases	261	26	26		10	26	72
73	Fully Depreciated Assets	358,588				10	358,588	73
74								74
75	TOTALS	$ 530,740	$ 430	$ 15,995	$ 15,565		$ 497,419	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		BUS	1997	$ 47,208	$	$	$	5	$ 35,408	76
77		Allocated from EC Consulting	2010	5,749	90	90		5	5,569	77
78		Alloc. From EC Clinical	2010	999	200	200		5	466	78
79										79
80	TOTALS			$ 53,956	$ 290	$ 290	$		$ 41,443	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)	$ 4,405,036	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 133,085	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 220,282	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 87,197	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,240,465	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.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions	Storage Unit Rental			1,456			4
5	Allocated From Extended Care Consulting				564			5
6								6
7	TOTAL				$ 2,020 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 6,139 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 156,898	$		$ 156,898	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			99,943			99,943	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			193,539			193,539	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				186,086		186,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					5,744	139,293		145,037	13
14	TOTAL			$		$ 456,124	$ 325,379		$ 781,503	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 98,034	$ 165,912	1
2	Cash-Patient Deposits	34,475	34,475	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	357,732	357,732	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	148,842	148,842	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	155,000	1,120,702	8
9	Other(specify): See Attached Schedule	2,887,164	2,895,465	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,681,247	$ 4,723,128	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		115,041	13
14	Buildings, at Historical Cost		3,016,824	14
15	Leasehold Improvements, at Historical Cost	709,344	709,344	15
16	Equipment, at Historical Cost	386,011	555,984	16
17	Accumulated Depreciation (book methods)	(872,548)	(2,205,607)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		6,808	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 222,807	$ 2,198,394	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,904,054	$ 6,921,522	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,661,223	$ 1,661,222	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,972	25,972	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	145,123	145,123	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,580	6,580	31
32	Accrued Real Estate Taxes(Sch.IX-B)	382,273	296,063	32
33	Accrued Interest Payable		311,356	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	691,325	939,910	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,912,496	$ 3,386,226	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,760,000	39
40	Mortgage Payable		1,400,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,160,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,912,496	$ 9,546,226	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 991,558	$ (2,624,704)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,904,054	$ 6,921,522	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 242,790	1
2	Restatements (describe):		2
3	**Contributions**	598,933	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 841,723	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(248,899)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	398,734	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)**	$ 149,835	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)**	$ 991,558	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,443,726	1
2	Discounts and Allowances for all Levels	(2,092,916)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,350,810	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,816,993	6
7	Oxygen	19,041	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,836,034	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	187,738	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,978	19
20	Radiology and X-Ray	3,840	20
21	Other Medical Services	121,475	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 350,031	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	41,092	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,092	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,059	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,059	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,585,026	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	892,693	31
32	Health Care	1,967,590	32
33	General Administration	1,353,831	33
	B. Capital Expense		
34	Ownership	752,618	34
	C. Ancillary Expense		
35	Special Cost Centers	821,203	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,833,925	40
41	**Income before Income Taxes (line 30 minus line 40)****	(248,899)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (248,899)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **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.** SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,943	2,160	$ 96,768	$ 44.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,133	8,998	249,882	27.77	3
4	Licensed Practical Nurses	20,795	23,077	551,209	23.89	4
5	CNAs & Orderlies	45,196	50,377	515,755	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,331	11,843	167,151	14.11	8
9	Activity Director	1,735	2,006	28,281	14.10	9
10	Activity Assistants	6,857	7,783	70,215	9.02	10
11	Social Service Workers	3,616	3,909	71,496	18.29	11
12	Dietician					12
13	Food Service Supervisor	1,821	2,115	43,928	20.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,854	8,287	80,583	9.72	15
16	Dishwashers	7,217	8,269	87,596	10.59	16
17	Maintenance Workers	2,540	2,658	52,861	19.89	17
18	Housekeepers	10,302	12,089	132,187	10.93	18
19	Laundry	4,472	5,127	66,282	12.93	19
20	Administrator	1,835	2,181	85,249	39.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,334	5,850	63,307	10.82	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	1,850	2,221	33,698	15.17	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	140,831	158,950	$ 2,396,448 *	$ 15.08	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	245	$ 11,843	01-03	35
36	Medical Director	Monthly	8,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	190	10-03	38
39	Pharmacist Consultant	Monthly	3,713	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	See Attached		73,361		47
48					48
49	TOTAL (lines 35 - 48)	245	$ 97,357		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marc. Halpert (1/1/10-10-18/10)	Administrator	0	$ 56,194
Denise Graves (9/3/10-12/31/10	Administrator	0	29,054
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,249

B. Administrative - Other

Description	Amount
Eric Rothner Management Fees	$ 8,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 8,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 24,000
See Attached	Legal	5,517
Personnel Planners	Unemployment Consult	2,224
Extended Care Consulting	Home Office Expenses	143,337
Extended Care Clinical	Home Office Expenses	46,370
Paycor	Payroll Services	8,225
E- Health Data Solutions	MDS Computer Services	3,180
AIS Assesment & Intelligence	MDS Consulting	773
National Datacare Corp	Resident Fund Processing	1,707
Vision Share	Computer Services	1,756
Michelle Frauendorff	Therapy Consultant	390
See Supplemetal Schedule		10,428
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 247,906

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,374
Unemployment Compensation Insurance	101,424
FICA Taxes	180,193
Employee Health Insurance	116,290
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	11,138
Holiday Expenses	1,600
Employee Physicals	1,690
Pension Expense	18,845
TOTAL (agree to Schedule V, line 22, col.8)	$ 490,553

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	657
Health Care Worker Background Check	
(Indicate # of checks performed 160)	3,640
Patient Background Checks	
Dues & Subscriptions	1,863
Licenses & Fees	910
Allocated From Ext. Care Consulting	1,473
Allocated From Ext. Care Clinical	83
See Supplemental Schedule	(131)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,490

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,995
Allocated From Ext. Care Consulting	72
Allocated From Ext. Care Clinical	662
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,729

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. **ILCLTC $7,421**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,493** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **45,990**
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. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **100% ln14**
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **No**

(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.