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.

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

I. IDPH License ID Number: 0041186

Facility Name: Tri-State Nsg & Rehab Ctr

Address: 2500 W. 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: 09/01/95

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 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	17,666	3,086	4,983	25,735	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,666	3,086	4,983	25,735	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.94%

D. How many bed-hold days during this year were paid by the Department?
13 (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 4,490

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	219,183	31,414	11,237	261,834		261,834	803	262,637			1
2	Food Purchase		135,918		135,918		135,918	(34)	135,884			2
3	Housekeeping	139,447	26,283		165,730		165,730	(1,118)	164,612			3
4	Laundry	55,157	16,191		71,348		71,348	(645)	70,703			4
5	Heat and Other Utilities			99,681	99,681		99,681	563	100,244			5
6	Maintenance	51,360		144,457	195,817		195,817	(42,759)	153,058			6
7	Other (specify):*							1,624	1,624			7
8	**TOTAL General Services**	465,147	209,806	255,375	930,328		930,328	(41,566)	888,762			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,526,819	101,246	26,982	1,655,047		1,655,047	18,111	1,673,158			10
10a	Therapy	146,628			146,628		146,628		146,628			10a
11	Activities	101,636	13,932		115,568		115,568	(4)	115,564			11
12	Social Services	169,001		6,901	175,902		175,902	3,100	179,002			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,372	7,372			15
16	**TOTAL Health Care and Programs**	1,944,084	115,178	51,883	2,111,145		2,111,145	28,579	2,139,724			16
	C. General Administration											
17	Administrative	86,302			86,302		86,302	24,519	110,821			17
18	Directors Fees											18
19	Professional Services			356,620	356,620	(10,170)	346,450	(250,335)	96,115			19
20	Dues, Fees, Subscriptions & Promotions			19,654	19,654		19,654	(5,242)	14,412			20
21	Clerical & General Office Expenses	67,742	16,880	339,705	424,327		424,327	(214,195)	210,132			21
22	Employee Benefits & Payroll Taxes			573,355	573,355		573,355	(17,922)	555,433			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,986	1,986		1,986	1,030	3,016			24
25	Other Admin. Staff Transportation			5,202	5,202		5,202	225	5,427			25
26	Insurance-Prop.Liab.Malpractice			117,359	117,359		117,359	500	117,859			26
27	Other (specify):*							17,927	17,927			27
28	**TOTAL General Administration**	154,044	16,880	1,413,881	1,584,805	(10,170)	1,574,635	(443,493)	1,131,142			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,563,275	341,864	1,721,139	4,626,278	(10,170)	4,616,108	(456,480)	4,159,628			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 Nsg & Rehab Ctr #0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			54,182	54,182		54,182	170,205	224,387			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,815	27,815		27,815	293,408	321,223			32
33	Real Estate Taxes			93,509	93,509	10,170	103,679	832	104,511			33
34	Rent-Facility & Grounds			379,412	379,412		379,412	(378,000)	1,412			34
35	Rent-Equipment & Vehicles			4,180	4,180		4,180	(948)	3,232			35
36	Other (specify):*											36
37	TOTAL Ownership			559,098	559,098	10,170	569,268	85,497	654,765			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		416,503	626,575	1,043,078		1,043,078	(34,323)	1,008,755			39
40	Barber and Beauty Shops			10	10		10		10			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,353	143,353		143,353		143,353			42
43	Other (specify):*			28,000	28,000		28,000	(28,000)				43
44	TOTAL Special Cost Centers		416,503	797,938	1,214,441		1,214,441	(62,323)	1,152,118			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,563,275	758,367	3,078,175	6,399,817		6,399,817	(433,306)	5,966,511			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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	88,553	30		9
10	Interest and Other Investment Income	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	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	(157)	21		18
19	Entertainment				19
20	Contributions	(2,633)	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	(269,955)	21		24
25	Fund Raising, Advertising and Promotional	(2,152)	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	(97,879)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (284,408)		$	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)	(148,898)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (148,898)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (433,306)		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 Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (47,763)	6	1
2	Other Income	(295)	21	2
3	Patient Clothing	(438)	10	3
4	Theft Loss	(582)	21	4
5	Collection Expense	(2,648)	21	5
6	Building Co - Bank Charges	(1,264)	21	6
7	Building Co - Land Trust Fees	(175)	20	7
8	Building Co - Amortization	(6,284)	36	8
9	Non-Allowable Office Expense	(28,000)	43	9
10	COPE Dues	(2,133)	20	10
11	Out of Period Legal Fees	(8,298)	19	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
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**	(97,879)		49

Tri-State Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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 Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			134		3,748		(3,053)	(26)				803	1
2	Food Purchase	(163)		129									(34)	2
3	Housekeeping			272		49			(1,439)				(1,118)	3
4	Laundry								(645)				(645)	4
5	Heat and Other Utilities			477		86							563	5
6	Maintenance	(47,763)		1,368	3,621	18						(3)	(42,759)	6
7	Other (specify):*				993	631							1,624	7
8	**TOTAL General Services**	(47,926)		2,380	4,614	4,532		(3,053)	(2,110)			(3)	(41,566)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(438)				20,916			(2,365)			(3)	18,111	10
10a	Therapy													10a
11	Activities								(4)				(4)	11
12	Social Services					3,100							3,100	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,043	3,329						7,372	15
16	**TOTAL Health Care and Programs**	(438)				28,059	3,329		(2,369)			(3)	28,579	16
	C. General Administration													
17	Administrative			1,429	4,866	18,224							24,519	17
18	Directors Fees													18
19	Professional Services	(8,298)		(187,912)		(54,125)							(250,335)	19
20	Fees, Subscriptions & Promotions	(7,093)	175	1,600		76							(5,242)	20
21	Clerical & General Office Expenses	(274,901)	1,264	5,927	49,744	3,771							(214,195)	21
22	Employee Benefits & Payroll Taxes				(14,580)		(3,329)		(13)				(17,922)	22
23	Inservice Training & Education													23
24	Travel and Seminar			88		942							1,030	24
25	Other Admin. Staff Transportation			225									225	25
26	Insurance-Prop.Liab.Malpractice			426		74							500	26
27	Other (specify):*				14,459	3,468							17,927	27
28	**TOTAL General Administration**	(290,292)	1,439	(178,217)	54,489	(27,570)	(3,329)		(13)				(443,493)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(338,655)	1,439	(175,837)	59,103	5,021		(3,053)	(4,492)			(6)	(456,480)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Tri-State Nsg & Rehab Ctr** **#** **0041186** **Report Period Beginning:** **01/01/11** **Ending:** **12/31/11**

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	88,553	76,346	4,601		705							170,205	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(22)	289,293	3,913		224							293,408	32
33	Real Estate Taxes			705		127							832	33
34	Rent-Facility & Grounds		(378,000)										(378,000)	34
35	Rent-Equipment & Vehicles			1,744						(2,692)			(948)	35
36	Other (specify):*	(6,284)	6,284											36
37	**TOTAL Ownership**	82,247	(6,077)	10,963		1,056				(2,692)			85,497	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(6,515)	(3,621)	(23,262)		(925)	(34,323)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(28,000)											(28,000)	43
44	**TOTAL Special Cost Centers**	(28,000)						(6,515)	(3,621)	(23,262)		(925)	(62,323)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(284,408)	(4,638)	(164,874)	59,103	6,077		(9,569)	(8,113)	(25,954)		(931)	(433,306)	45

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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	$ 378,000	Lansing Healthcare Properties	100.00%	$	$ (378,000)	1
2	V	33	Real Estate Taxes	93,508	Lansing Healthcare Properties	100.00%	93,508		2
3	V	32	Interest	335	Lansing Healthcare Properties	100.00%	289,628	289,293	3
4	V	21	Bank Charges		Lansing Healthcare Properties	100.00%	1,264	1,264	4
5	V	20	Land Trust Fees		Lansing Healthcare Properties	100.00%	175	175	5
6	V	21	State Replacement Tax		Lansing Healthcare Properties	100.00%			6
7	V	30	Depreciation		Lansing Healthcare Properties	100.00%	76,346	76,346	7
8	V	36	Amortization		Lansing Healthcare Properties	100.00%	6,284	6,284	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 471,843			$ 467,205	$ * (4,638)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 134	$ 134	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	129	129	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	272	272	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	477	477	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,368	1,368	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,429	1,429	20
21	V	19	Professional Fees	191,928	Extended Care Consulting, LLC	100.00%	2,672	(187,912)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,600	1,600	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	5,927	5,927	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	88	88	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	225	225	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	426	426	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	4,601	4,601	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	3,913	3,913	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	705	705	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,744	1,744	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 191,928			$ 25,710	$ * (164,874)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	3,621	$ 3,621	15
16	V	06	Maintenance (Direct)	2,769	Extended Care Consulting, LLC	100.00%	2,769		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	649	649	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	344	344	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	4,866	4,866	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	49,744	49,744	22
23	V	21	Office and Clerical (Direct)	18,604	Extended Care Consulting, LLC	100.00%	18,604		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	9,396	9,396	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,063	5,063	25
26	V	22	Employee Benefits	14,580	Extended Care Consulting, LLC	100.00%		(14,580)	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			$ 35,953			$ 95,056	$ * 59,103	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 49	$ 49	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	86	86	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	18	18	17
18	V	19	Professional Fees	63,528	Extended Care Clinical, LLC	100.00%	9,403	(54,125)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	76	76	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,390	1,390	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	942	942	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	74	74	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	705	705	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	224	224	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	127	127	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	3,748	3,748	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	631	631	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	20,916	20,916	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	3,100	3,100	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,043	4,043	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	18,224	18,224	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	2,381	2,381	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	3,468	3,468	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,528			$ 69,605	$ * 6,077	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing / Medical Record Salary	22,444	Extended Care Clinical, LLC	100.00%	22,444		17
18	V	12	Social Service / Admission Salary	6,901	Extended Care Clinical, LLC	100.00%	6,901		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,329	3,329	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	3,329	Extended Care Clinical, LLC	100.00%		(3,329)	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			$ 32,674			$ 32,674	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 6,371	Care Centers Health Systems, Inc.	100.00%	$ 3,318	$ (3,053)	15
16	V	2	Food		Care Centers Health Systems, Inc.	100.00%			16
17	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			17
18	V	39	Ancillary Expense	13,595	Care Centers Health Systems, Inc.	100.00%	7,080	(6,515)	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			$ 19,966			$ 10,398	$ * (9,569)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 425	Xcel Supply, LLC	100.00%	$ 399	$ (26)	15
16	V	3	Housekeeping	23,730	Xcel Supply, LLC	100.00%	22,292	(1,439)	16
17	V	4	Laundry	10,645	Xcel Supply, LLC	100.00%	9,999	(645)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	39,010	Xcel Supply, LLC	100.00%	36,645	(2,365)	19
20	V	11	Activities	70	Xcel Supply, LLC	100.00%	66	(4)	20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits	214	Xcel Supply, LLC	100.00%	201	(13)	22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	59,735	Xcel Supply, LLC	100.00%	56,114	(3,621)	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			$ 133,828			$ 125,715	$ * (8,113)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	39	Ventilator Equipment	35,285	Vent Lease LLC	100.00%	12,023	(23,262)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	2,692	Vent Lease LLC	100.00%		(2,692)	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			$ 37,977			$ 12,023	$ * (25,954)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 99,721	$ 99,721	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	99,721	CCS Employee Benefits Group	100.00%		(99,721)	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			$ 99,721			$ 99,721	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 356	Reliable Medical of the Midwest, LLC	100.00%	$ 353	$ (3)	15
16	V	10	Nursing Supplies	317	Reliable Medical of the Midwest, LLC	100.00%	314	(3)	16
17	V	39	Ancillary Expense	103,387	Reliable Medical of the Midwest, LLC	100.00%	102,463	(925)	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			$ 104,061			$ 103,130	$ * (931)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES TRUST	4.762%			LANSING HEALTHCARE PROPI		BUILDING CO.	1
2	DANIEL ROTHNER TRUST	4.761%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTINC	EVANSTON	MANAGEMENT/BOOKKI	2
3	ERIC ROTHNER	1.191%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	KATHRYN VALES TRUST	4.762%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5	KIMBERLY RICHMAN TRUST	4.762%	BRIAR PLACE, LTD.	INDIAN HEAD	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6	MELISSA ROTHNER TRUST	4.762%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7	NATHAN AND SHIRLEY ROTHNER	65.476%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	VENTLEASE, LLC	EVANSTON	VENTALATOR RENTAL	7
8	RACHEL ROTHNER TRUST	4.762%	DYER NURSING & REHAB	DYER, IN	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9	WILLIAM ROTHNER TRUST	4.762%	GRASMERE PLACE, LLC	CHICAGO	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	9
10			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				10
11			HOMESTEAD NURSING & REAHB	LINCOLN, NE				11
12			GOLDEN PLAINES	HUTCHINSON, KS				12
13			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				14
15			LANCASTER MANOR	LINCOLN, NE				15
16			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17			MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOLBART, IN				23
24								24
25			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			WHEATON CARE CENTER	WHEATON				29
30								30

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	G. Matt Silvers	Relative	Administrative	0%	See Attached	0.43	1.08%	Alloc. Salary	$ 1,678	17-7	1
2	Adam Vales	Owner	Clerical	4.76%	See Attached	0.73	1.83%	Alloc. Salary	1,301	22-7	2
3	Mark Steinberg	Relative	Administrative	0%	See Attached	1.69	3.07%	Alloc. Salary	5,548	17-7	3
4											4
5											5
6											6
7											7
8											8
9	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										9
10	the IL Dept of HFS										10
11											11
12											12
13								TOTAL	$ 8,527		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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,332,501	31	$ 6,942	$	25,735	$ 134	1
2	02	Food	Patient Days	1,332,501	31	6,677		25,735	129	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		25,735	272	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		25,735	477	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		25,735	1,368	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		25,735	1,429	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		25,735	2,672	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		25,735	1,600	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		25,735	5,927	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		25,735	88	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		25,735	225	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		25,735	426	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		25,735	4,601	13
14	32	Interest	Patient Days	1,332,501	31	202,602		25,735	3,913	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		25,735	705	15
16	34	Rent - Building	Patient Days	1,332,501	31			25,735		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		25,735	1,744	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 25,710	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,332,501	31	187,474	187,474	25,735	3,621	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		2,769	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		25,735	649	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			344	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	25,735	4,866	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	25,735	49,744	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		18,604	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		25,735	9,396	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			5,063	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					$ 4,298,198	$ 3,682,723		$ 95,056	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	817,528	19	$ 1,549	$	25,735	$ 49	1
2	05	Utilities	Patient Days	817,528	19	2,718		25,735	86	2
3	06	Maintenance	Patient Days	817,528	19	557		25,735	18	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		25,735	9,403	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		25,735	76	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		25,735	1,390	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		25,735	942	7
8	26	Insurance	Patient Days	817,528	19	2,346		25,735	74	8
9	30	Depreciation	Patient Days	817,528	19	22,389		25,735	705	9
10	32	Interest	Patient Days	817,528	19	7,100		25,735	224	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		25,735	127	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	25,735	3,748	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		25,735	631	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	25,735	20,916	14
15	10a	Rehab Salary	Patient Days	817,528	19			25,735		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	25,735	3,100	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		25,735	4,043	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	25,735	18,224	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	25,735	2,381	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		25,735	3,468	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 69,605	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		22,444	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		6,901	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			3,329	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 32,674	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$ 3,318	1
2	2	Food	Direct Allocation							2
3	10	Nursing Supplies	Direct Allocation							3
4	39	Ancillary Expense	Direct Allocation						7,080	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					$	$		$ 10,398	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$ 399	1
2	3	Housekeeping	Direct Allocation						22,292	2
3	4	Laundry	Direct Allocation						9,999	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						36,645	5
6	11	Activities	Direct Allocation						66	6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation						201	8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						56,114	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					$	$		$ 125,715	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	39	Ventilator Equipment	Direct Allocation						12,023	1
2	39	Other Ancillary	Direct Allocation							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					$	$		$ 12,023	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$ 99,721	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					$	$		$ 99,721	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$ 353	1
2	10	Nursing Supplies	Direct Allocation						314	2
3	39	Ancillary Expense	Direct Allocation						102,463	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					$	$		$ 103,130	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$ 80,767	1
2	Cole Taylor Bank		X	Note Payable				4,500,000			182,500	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	DIAWA Loan		X	Line of Credit				1,398,578			27,815	6
7	Fairfax HC Properties		X					260,000			26,361	7
8	See Supplemental Schedule										4,137	8
9	TOTAL Facility Related				$22,010.00		$ 2,620,000	$ 7,558,578			$ 321,580	9
	B. Non-Facility Related*											
10	Interest Income		X								(22)	10
11	Interest Incom - Bldg. Co		X								(335)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (357)	14
15	TOTALS (line 9+line14)						$ 2,620,000	$ 7,558,578			$ 321,223	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From EC Consult.						$	$			$ 3,913	8
9	Allocated From EC Clinical										224	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										4,137	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 Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 296,063	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.)		$ 190,867	2
3. Under or (over) accrual (line 2 minus line 1).		$ (105,196)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 199,537	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.**		$ 10,170	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.		$ 104,511	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	174,960	8
2007	181,917	9
2008	241,978	10
2009	281,966	11
2010	190,035	12

2011 Accrual = $190,035 x 1.05 = $199,537

Allocated From Extended Care Consulting: $705

Allocated From Extended Care Clinical: $127

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nsg & 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(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	$ 190,035.26	$ 190,035.26
2.	See Attached	Allocation from 2201 Main	$ 126,481.18	$ 1,161.64
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 316,516.44	$ 191,196.90

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			7,531	2
3	TOTALS			$ 92,517	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	84			1962	$ 2,932,035	$ 76,346	39	$ 146,602	$ 70,256	$ 2,394,498	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,222	1,222	19,874	9
10	Various			1996	82,791		20	4,140	4,140	65,111	10
11	Various			1997	44,854		20	2,243	2,243	32,557	11
12	Various			1998	47,497		20	2,271	2,271	33,621	12
13	Various			1999	39,389		20	1,969	1,969	25,058	13
14	Various			2000	13,995		20	700	700	8,017	14
15	Various			2001	20,621		20	1,031	1,031	11,017	15
16	Various			2002	8,353		20	642	642	7,062	16
17	Various			2003	20,578		20	1,556	1,556	13,366	17
18	Various			2004	61,438		20	5,338	5,338	46,213	18
19	Various			2005	140,855		20	13,971	13,971	83,534	19
20	Various			2006	29,295		20	2,495	2,495	19,742	20
21	Various			2007	102,339		20	8,914	8,914	68,699	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		7,149			357	357	774	67
68	Related Party Allocations (Pages 12H & 12I)		30,498	2,074		2,074		16,536	68
69	Financial Statement Depreciation			54,182			(54,182)		69
70	TOTAL (lines 4 thru 69)		$ 3,606,118	$ 132,602		$ 195,524	$ 62,922	$ 2,845,677	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,606,118	$ 132,602		$ 195,524	$ 62,922	$ 2,845,677	1
2	Painting (Transfer From Home Office)	2008	5,208		20			5,208	2
3	Install Fire Alarms & New Smoke Detectors	2008	3,335		20	476	476	1,906	3
4	14 Coaxial Cable Runs	2008	2,602		20	260	260	1,019	4
5	Painting (Transfer From Home Office)	2008	5,424		20			5,424	5
6	Painting (Transfer From Home Office)	2008	10,282		20			10,282	6
7	Painting (Transfer From Home Office)	2008	5,909		20			5,909	7
8	Painting (Transfer From Home Office)	2008	5,302		20			5,302	8
9	2 New Laundry Rooms	2008	15,900		20	1,590	1,590	5,565	9
10	New Condensing Unit	2008	3,503		20	350	350	1,226	10
11	Telephone System Upgrade	2008	4,299		20	430	430	1,469	11
12	Remodel Entire Shower Room	2008	10,500		20	1,050	1,050	3,413	12
13	Heating Repairs	2008	2,644		20	264	264	837	13
14	Heating Repairs	2008	11,201		20	1,120	1,120	3,547	14
15	Hvac Repairs	2009	23,976		20	2,398	2,398	5,994	15
16	Electrical Conduit Repair	2009	6,250		20	625	625	1,563	16
17	Plumbing Repairs	2009	5,300		20	530	530	1,193	17
18	Roof	2009	10,575		20	1,058	1,058	2,379	18
19	Refund Of Insurance Proceeds - Ceiling Cave In	2009	(5,392)		20	(539)	(539)	(1,618)	19
20	Landmark Adjustment - Ceiling	2009	(15,000)		20	(1,500)	(1,500)	(4,500)	20
21	Walk In Cooler	2009	3,066		20	307	307	639	21
22	Heat Sensors	2010	6,378		20	638	638	691	22
23	Piping	2010	2,565		20	128	128	246	23
24	Painting	2010	2,906		20	145	145	242	24
25	Flooring	2011	30,564		20	2,292	2,292	2,292	25
26	New Hvac Unit	2011	20,366		20	1,117	1,117	1,117	26
27	Sprinkler System Repair	2011	6,584		20	165	165	165	27
28	Roof	2011	54,600		20	883	883	883	28
29	Wall Guards	2011	4,995		20	999	999	999	29
30	Painting	2011	47,763		20	199	199	199	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,897,724	$ 132,602		$ 210,509	$ 77,907	$ 2,909,267	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,897,724	$ 132,602		$ 210,509	$ 77,907	$ 2,909,267	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)		$ 3,897,724	$ 132,602		$ 210,509	$ 77,907	$ 2,909,267	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,897,724	$ 132,602		$ 210,509	$ 77,907	$ 2,909,267	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 (lines 1 thru 33)		$ 3,897,724	$ 132,602		$ 210,509	$ 77,907	$ 2,909,267	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,897,724	$ 132,602		$ 210,509	$ 77,907	$ 2,909,267	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
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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)		$ 3,897,724	$ 132,602		$ 210,509	$ 77,907	$ 2,909,267	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Heating Repairs	2008	7,149		20	357	357	774	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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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)		$ 7,149	$		$ 357	$ 357	$ 774	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	8,798	226	20	226		2,096	3
4	Allocated From Extended Care Clinical 2201 Main	2002	1,580	41	20	41		376	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated From Extended Care Consulting	2007	89	4	20	4		22	10
11	Allocated From Extended Care Consulting	2009	53	3	20	3		8	11
12	Allocated From Extended Care Consulting	2010	521	26	20	26		52	12
13	Allocated From Extended Care Consulting	2011	188	9	20	9		9	13
14									14
15	Allocated From Extended Care Consulting 2201 Main	2002	7,268	664	20	664		5,320	15
16	Allocated From Extended Care Consulting 2201 Main	2003	8,565	783	20	783		6,270	16
17	Allocated From Extended Care Consulting 2201 Main	2005	426	45	20	45		244	17
18	Allocated From Extended Care Consulting 2201 Main	2009	77	4	20	4		12	18
19									19
20	Allocated From Extended Care Clinical 2201 Main	2002	1,305	119	20	119		955	20
21	Allocated From Extended Care Clinical 2201 Main	2003	1,538	141	20	141		1,126	21
22	Allocated From Extended Care Clinical 2201 Main	2005	76	8	20	8		44	22
23	Allocated From Extended Care Clinical 2201 Main	2009	14	1	20	1		2	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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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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 (12H & 12I lines 1 thru 33)		$ 30,498	$ 2,074		$ 2,074	$	$ 16,536	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 160,700	$ 482	$ 11,128	$ 10,646	10	$ 135,725	71
72	Current Year Purchases	20,752	2,302	2,302		10	18,614	72
73	Fully Depreciated Assets	374,625				10	374,625	73
74								74
75	TOTALS	$ 556,077	$ 2,784	$ 13,430	$ 10,646		$ 528,964	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	1997	$ 47,208	$	$	$	5	$ 35,408	76
77		Allocated from EC Consulting	2011	6,210	97	97		5	6,113	77
78		Alloc. From EC Clinical	2011	1,760	352	352		5	1,173	78
79										79
80	TOTALS			$ 55,178	$ 449	$ 449	$		$ 42,694	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)	$ 4,601,496	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,835	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,388	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 88,553	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,480,924	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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							4
5	Storage Unit Rental				1,412			5
6								6
7	TOTAL				$ 1,412 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 3,232 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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 211,776	$		$ 211,776	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			101,279			101,279	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			251,769			251,769	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				250,235		250,235	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					61,751	166,268		228,019	13
14	TOTAL			$		$ 626,575	$ 416,503		$ 1,043,078	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 Nsg & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/11 **(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	$ 127,760	$ 289,433	1
2	Cash-Patient Deposits	39,994	39,994	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,378,135	1,378,135	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,407	149,407	6
7	Other Prepaid Expenses	4,694	4,694	7
8	Accounts Receivable (owners or related parties)	155,000	1,050,702	8
9	Other(specify): See Attached Schedule	306,308	459,353	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,161,298	$ 3,371,718	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		2,972,860	14
15	Leasehold Improvements, at Historical Cost	819,779	819,779	15
16	Equipment, at Historical Cost	391,006	560,979	16
17	Accumulated Depreciation (book methods)	(926,730)	(2,336,135)	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	295	819	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 284,350	$ 2,133,343	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,445,648	$ 5,505,061	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,152,668	$ 2,089,667	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,163	26,163	28
29	Short-Term Notes Payable	1,398,578	1,398,578	29
30	Accrued Salaries Payable	160,195	160,195	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,726	8,726	31
32	Accrued Real Estate Taxes(Sch.IX-B)	199,537	199,537	32
33	Accrued Interest Payable		337,717	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	654,608	934,892	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,600,475	$ 5,155,475	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)**	$ 4,600,475	$ 11,315,475	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,154,827)	$ (5,810,414)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,445,648	$ 5,505,061	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 991,558	1
2	Restatements (describe):		2
3	**Distributions/Contributions**	(2,771,237)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,779,679)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(375,148)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (375,148)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,154,827)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 5,812,529	1
2	Discounts and Allowances for all Levels	(2,475,417)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,337,112	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,206,040	6
7	Oxygen	12,834	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,218,874	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	258,773	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,617	19
20	Radiology and X-Ray	3,980	20
21	Other Medical Services	170,996	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 468,366	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	295	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 295	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,024,669	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	930,328	31
32	Health Care	2,111,145	32
33	General Administration	1,584,805	33
	B. Capital Expense		
34	Ownership	559,098	34
	C. Ancillary Expense		
35	Special Cost Centers	1,071,088	35
36	Provider Participation Fee	143,353	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,399,817	40
41	**Income before Income Taxes (line 30 minus line 40)****	(375,148)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (375,148)	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,773	1,990	$ 92,958	$ 46.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,707	6,601	192,527	29.17	3
4	Licensed Practical Nurses	24,334	26,185	669,275	25.56	4
5	CNAs & Orderlies	45,335	50,376	520,398	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,739	9,848	146,628	14.89	8
9	Activity Director	1,750	1,923	27,913	14.52	9
10	Activity Assistants	7,087	8,112	73,723	9.09	10
11	Social Service Workers	6,386	6,694	169,001	25.25	11
12	Dietician					12
13	Food Service Supervisor	1,870	2,207	48,367	21.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,876	7,908	82,997	10.50	15
16	Dishwashers	6,905	8,091	87,819	10.85	16
17	Maintenance Workers	2,248	2,712	51,360	18.94	17
18	Housekeepers	11,723	13,080	139,447	10.66	18
19	Laundry	3,391	3,903	55,157	14.13	19
20	Administrator	1,921	2,192	86,302	39.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,912	6,604	67,742	10.26	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	2,161	34,692	16.05	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,054	1,253	16,969	13.54	33
34	TOTAL (lines 1 - 33)	144,861	161,840	$ 2,563,275 *	$ 15.84	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	246	$ 11,237	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,538	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		29,345		47
48					48
49	TOTAL (lines 35 - 48)	246	$ 63,120		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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Elkaim	Administrator	0	$ 86,303
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,303

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 24,000
See Attached	Legal	50,479
Extended Care Consulting	Home Office Expenses	190,584
Extended Care Clinical	Home Office Expenses	63,528
Personnel Planners	Unemployment Consult	2,018
Pinnacle Consulting	Customer Satisfaction	2,418
Blymas	Tax Consulting	1,266
Extended Care Consulting	Other Professional Services	1,344
Prospect Resources	Natural Gas Procurement	758
LaSalle Apraisal Group	Apraisal Services	4,000
Michelle Frauendorff	Therapy Consultant	130
See Supplemetal Schedule		16,094
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 356,620

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,204
Unemployment Compensation Insurance	126,512
FICA Taxes	193,511
Employee Health Insurance	120,747
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	3,814
Pension Expense	21,337
Other Employee Welfare	4,248
Holiday Expenses	2,060
TOTAL (agree to Schedule V, line 22, col.8)	$ 555,433

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	$
Advertising: Employee Recruitment	509
Health Care Worker Background Check	
(Indicate # of checks performed 356)	4,797
Patient Background Checks	
Dues & Subscriptions	5,422
Licenses & Fees	2,008
Allocated From Ext. Care Consulting	1,600
Allocated From Ext. Care Clinical	76
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,413

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,986
Allocated From Ext. Care Consulting	88
Allocated From Ext. Care Clinical	942
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,016

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/11 Ending: 12/31/11

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													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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 $7,749**

(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. $ **24,410** 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. $ **143,353**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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?
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.