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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	20,496	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,248	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,744	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	19,477	987	6,094	26,558	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,477	987	6,094	26,558	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.38%

D. How many bed-hold days during this year were paid by the Department?
None (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 5,756

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: 12/31/12 Fiscal Year: 12/31/12

* 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: 01/01/12 Ending: 12/31/12

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	221,875	35,953	14,247	272,075		272,075	2,277	274,352			1
2	Food Purchase		141,646		141,646		141,646	211	141,857			2
3	Housekeeping	116,354	29,787		146,141		146,141	331	146,472			3
4	Laundry	68,132	8,470		76,602		76,602		76,602			4
5	Heat and Other Utilities			82,964	82,964		82,964	479	83,443			5
6	Maintenance	65,991		100,944	166,935		166,935	(35,238)	131,697			6
7	Other (specify):*							2,473	2,473			7
8	TOTAL General Services	472,352	215,856	198,155	886,363		886,363	(29,467)	856,896			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,618,808	88,544	4,717	1,712,069		1,712,069	30,612	1,742,681			10
10a	Therapy	126,541			126,541		126,541		126,541			10a
11	Activities	103,718	16,502		120,220		120,220		120,220			11
12	Social Services	189,394		597	189,991		189,991	12,461	202,452			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,288	7,288			15
16	TOTAL Health Care and Programs	2,038,461	105,046	21,814	2,165,321		2,165,321	50,361	2,215,682			16
	C. General Administration											
17	Administrative	92,673			92,673		92,673	47,993	140,666			17
18	Directors Fees											18
19	Professional Services			379,177	379,177	(27,146)	352,031	(260,356)	91,675			19
20	Dues, Fees, Subscriptions & Promotions			22,303	22,303		22,303	(6,633)	15,670			20
21	Clerical & General Office Expenses	88,193	21,534	96,162	205,889		205,889	791	206,680			21
22	Employee Benefits & Payroll Taxes			611,043	611,043		611,043	(7,866)	603,177			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,384	5,384		5,384	254	5,638			24
25	Other Admin. Staff Transportation			4,719	4,719		4,719	458	5,177			25
26	Insurance-Prop.Liab.Malpractice			183,311	183,311		183,311	853	184,164			26
27	Other (specify):*							20,255	20,255			27
28	TOTAL General Administration	180,866	21,534	1,302,099	1,504,499	(27,146)	1,477,353	(204,251)	1,273,102			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,691,679	342,436	1,522,068	4,556,183	(27,146)	4,529,037	(183,357)	4,345,680			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: 01/01/12 Ending: 12/31/12

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			58,549	58,549		58,549	171,831	230,380			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,675	60,675		60,675	142,668	203,343			32
33	Real Estate Taxes			162,022	162,022	27,146	189,168	1,521	190,689			33
34	Rent-Facility & Grounds			378,000	378,000		378,000	(378,000)				34
35	Rent-Equipment & Vehicles			2,851	2,851		2,851	423	3,274			35
36	Other (specify):*											36
37	**TOTAL Ownership**			662,097	662,097	27,146	689,243	(61,557)	627,686			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		477,398	837,299	1,314,697		1,314,697	(17,336)	1,297,361			39
40	Barber and Beauty Shops			70	70		70		70			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,354	172,354		172,354		172,354			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		477,398	1,009,723	1,487,121		1,487,121	(17,336)	1,469,785			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,691,679	819,834	3,193,888	6,705,401		6,705,401	(262,249)	6,443,152			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: 01/01/12 Ending: 12/31/12

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	90,800	30		9
10	Interest and Other Investment Income	(636)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(53)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	21		24
25	Fund Raising, Advertising and Promotional	(6,088)	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	(32,138)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,885		$	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)	(266,134)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (266,134)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (262,249)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE Dues	$ (2,604)	20	1
2	Patient Clothing	(486)	10	2
3	Theft Loss	(520)	21	3
4	Collection Expense	(7,015)	21	4
5	Building Company - Legal	(3,835)	19	5
6	Building Company - Bank Charges	(879)	21	6
7	Building Company - Amortization	(524)	36	7
8	Other Income	(7,861)	21	8
9	2011 Seminar	(105)	24	9
10	2013 Seminar	(600)	24	10
11	Non-Allowable Legal Expense	(7,709)	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**	(32,138)		49

Tri-State Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/12

Ending: 12/31/12

	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:** 01/01/12 **Ending:** 12/31/12

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			138		5,425	(3,286)						2,277	1
2	Food Purchase	(53)		264									211	2
3	Housekeeping			264		67							331	3
4	Laundry													4
5	Heat and Other Utilities			382		97							479	5
6	Maintenance		(40,320)	1,514	3,538	30							(35,238)	6
7	Other (specify):*				1,574	899							2,473	7
8	**TOTAL General Services**	(53)	(40,320)	2,562	5,112	6,518	(3,286)						(29,467)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(486)				31,098							30,612	10
10a	Therapy													10a
11	Activities													11
12	Social Services					12,461							12,461	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,288							7,288	15
16	**TOTAL Health Care and Programs**	(486)				50,847							50,361	16
	C. General Administration													
17	Administrative			1,635	7,658	38,700							47,993	17
18	Directors Fees													18
19	Professional Services	(11,544)	3,835	(169,480)		(83,167)							(260,356)	19
20	Fees, Subscriptions & Promotions	(8,692)		2,005		54							(6,633)	20
21	Clerical & General Office Expenses	(64,275)	879	6,844	53,753	3,590							791	21
22	Employee Benefits & Payroll Taxes				(7,793)	(73)							(7,866)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(705)		123		836							254	24
25	Other Admin. Staff Transportation			458									458	25
26	Insurance-Prop.Liab.Malpractice			540		313							853	26
27	Other (specify):*				13,449	6,806							20,255	27
28	**TOTAL General Administration**	(85,216)	4,714	(157,875)	67,067	(32,941)							(204,251)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,755)	(35,606)	(155,313)	72,179	24,424	(3,286)						(183,357)	29

STATE OF ILLINOIS

Summary B

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

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	90,800	76,346	3,843		842							171,831	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(636)	125,113	2,390		15,801							142,668	32
33	Real Estate Taxes			1,212		309							1,521	33
34	Rent-Facility & Grounds		(378,000)										(378,000)	34
35	Rent-Equipment & Vehicles			591				(168)					423	35
36	Other (specify):*	(524)	524											36
37	**TOTAL Ownership**	89,640	(176,017)	8,036		16,952		(168)					(61,557)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(825)	(16,248)		(263)			(17,336)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(825)	(16,248)		(263)			(17,336)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,885	(211,623)	(147,277)	72,179	41,376	(4,111)	(16,415)		(263)			(262,249)	45

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

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	Rent	$ 378,000	Lansing Healthcare Properties	100.00%	$	$ (378,000)	1
2	V	33	Real Estate Tax	65,367			65,367		2
3	V	32	Interest	74			125,187	125,113	3
4	V	19	Legal				3,835	3,835	4
5	V	21	Bank Charges				879	879	5
6	V	30	Depreciation				76,346	76,346	6
7	V	36	Amortization				524	524	7
8	V	6	Rental Income - Sign	40,320				(40,320)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 483,761			$ 272,138	$ * (211,623)	14

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

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

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%	$ 138	$ 138	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	264	264	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	264	264	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	382	382	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,514	1,514	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,635	1,635	20
21	V	19	Professional Fees	171,792	Extended Care Consulting, LLC	100.00%	2,312	(169,480)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,005	2,005	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,844	6,844	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	123	123	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	458	458	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	540	540	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,843	3,843	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	2,390	2,390	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,212	1,212	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%	591	591	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 171,792			$ 24,515	$ * (147,277)	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: 01/01/12 Ending: 12/31/12

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%	3,538	$ 3,538	15
16	V	06	Maintenance (Direct)	7,630	Extended Care Consulting, LLC	100.00%	7,630		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	650	650	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	924	924	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	7,658	7,658	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	53,753	53,753	22
23	V	21	Office and Clerical (Direct)	17,873	Extended Care Consulting, LLC	100.00%	17,873		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	11,283	11,283	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,166	2,166	25
26	V	22	Employee Benefits	7,793	Extended Care Consulting, LLC	100.00%		(7,793)	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			$ 33,296			$ 105,475	$ * 72,179	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: 01/01/12 Ending: 12/31/12

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%	$ 67	$ 67	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	97	97	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	30	30	17
18	V	19	Professional Fees	84,612	Extended Care Clinical, LLC	100.00%	1,445	(83,167)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	54	54	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,201	1,201	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	836	836	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	313	313	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	842	842	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	15,801	15,801	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	309	309	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	5,425	5,425	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	899	899	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	31,098	31,098	28
29	V								29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	12,461	12,461	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,215	7,215	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	38,700	38,700	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	2,389	2,389	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,806	6,806	34
35	V	10	Nursing / Medical Record Salary	121	Extended Care Clinical, LLC	100.00%	121		35
36	V	12	Social Service / Admission Salary	597	Extended Care Clinical, LLC	100.00%	597		36
37	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	73	73	37
38	V	22	Employee Benefits	73	Extended Care Clinical, LLC	100.00%		(73)	38
39	Total			$ 85,403			$ 126,779	$ * 41,376	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: 01/01/12 Ending: 12/31/12

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	$ 11,736	Care Centers Health Systems, Inc.	100.00%	$ 8,450	$ (3,286)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	2,948	Care Centers Health Systems, Inc.	100.00%	2,123	(825)	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			$ 14,684			$ 10,573	$ * (4,111)	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: 01/01/12 Ending: 12/31/12

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	28,530	Vent Lease LLC	100.00%	12,282	$ (16,248)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	168	Vent Lease LLC	100.00%		(168)	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			$ 28,698			$ 12,282	$ * (16,415)	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: 01/01/12 Ending: 12/31/12

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. ☐ 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%	$ 125,043	$ 125,043	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	125,043	CCS Employee Benefits Group	100.00%		(125,043)	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			$ 125,043			$ 125,043	$ *	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: 01/01/12 Ending: 12/31/12

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	Ancillary Expense	29,518	Reliable Medical of the Midwest, LLC	100.00%	29,255	$ (263)	15
16	V								16
17	V								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			$ 29,518			$ 29,255	$ * (263)	39

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

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

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	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: 01/01/12 Ending: 12/31/12

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	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: 01/01/12 Ending: 12/31/12

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	4.761%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	LANSING HEALTHCARE PROPI		BUILDING CO.	1
2	DANIEL ROTHNER TRUST	4.761%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	ERIC ROTHNER	1.190%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	KATHRYN VALES TRUST	4.761%	BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5	KIMBERLY RICHMAN TRUST	4.761%	CHATEAU NURSING AND REHABILITATION CENTER, LLC	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	MELISSA ROTHNER TRUST	4.761%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	VENT LEASE, LLC	EVANSTON	VENTILATOR RENTAL	6
7	NATHAN AND SHIRLEY ROTHNER	65.476%	DEVON GABLES REHABILITATION CENTER	ARIZONA	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	7
8	RACHEL ROTHNER TRUST	4.761%	DYER NURSING & REHAB	DYER, IN	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	8
9	WILLIAM ROTHNER TRUST	4.761%	FOOTHILLS REHABILITATION CENTER LLC	ARIZONA				9
10			GOLDEN PLAINES REHABILITATION CENTER	KANSAS				10
11			GRASMERE PLACE, LLC	CHICAGO				11
12			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				12
13			HOMESTEAD NURSING & REAHB	LINCOLN, NE				13
14			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				14
15			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				15
16			LANCASTER MANOR	LINCOLN, NE				16
17			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				17
18			MCKINLEY HEALTH CARE CENTER	CANTON, OH				18
19			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				19
20			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				20
21			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				21
22			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				22
23			RAINBOW BEACH QOC, L.L.C.	CHICAGO				23
24			SEBOS NURSING & REHAB	HOLBART, IN				24
25			SHEFFIELD MANOR	DYER, IN				25
26			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				26
27			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				27
28			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				28
29			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				29
30			WHEATON CARE CENTER	WHEATON				30

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

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: 01/01/12 Ending: 12/31/12

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	Adam Vales	Relative	Clerical	0	See Attached	1.07	2.68%	Alloc. Salary	$ 1,961	22-7	1
2	Mark Steinberg	Relative	Administrative	0	See Attached	1.75	3.18%	Alloc Sal/Fee	6,097	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 8,058		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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	1,364,178	31	$ 7,101	$	26,558	$ 138	1
2	02	Food	Patient Days	1,364,178	31	13,586		26,558	264	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		26,558	264	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		26,558	382	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		26,558	1,514	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		26,558	1,635	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		26,558	2,312	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		26,558	2,005	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		26,558	6,844	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		26,558	123	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		26,558	458	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		26,558	540	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		26,558	3,843	13
14	32	Interest	Patient Days	1,364,178	31	122,765		26,558	2,390	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		26,558	1,212	15
16	34	Rent - Building	Patient Days	1,364,178	31			26,558		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		26,558	591	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 24,515	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,364,178	31	181,713	181,713	26,558	3,538	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754		7,630	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		26,558	650	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137			924	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	26,558	7,658	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	26,558	53,753	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		17,873	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		26,558	11,283	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			2,166	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					$ 4,679,511	$ 3,961,379		$ 105,475	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	611,520	14	$ 1,549	$	26,558	$ 67	1
2	05	Utilities	Patient Days	611,520	14	2,241		26,558	97	2
3	06	Maintenance	Patient Days	611,520	14	691		26,558	30	3
4	19	Professional Fees	Patient Days	611,520	14	33,266		26,558	1,445	4
5	20	Dues and Subscriptions	Patient Days	611,520	14	1,249		26,558	54	5
6	21	Office & Clerical	Patient Days	611,520	14	27,644		26,558	1,201	6
7	24	Travel and Seminar	Patient Days	611,520	14	19,257		26,558	836	7
8	26	Insurance	Patient Days	611,520	14	7,216		26,558	313	8
9	30	Depreciation	Patient Days	611,520	14	19,393		26,558	842	9
10	32	Interest	Patient Days	611,520	14	363,826		26,558	15,801	10
11	33	Real Estate Taxes	Patient Days	611,520	14	7,106		26,558	309	11
12	01	Dietary Salary	Patient Days	611,520	14	124,907	124,907	26,558	5,425	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	611,520	14	20,691		26,558	899	13
14	10	Nursing Salary	Patient Days	611,520	14	716,058	716,058	26,558	31,098	14
15										15
16	12	Social Service Salary	Patient Days	611,520		286,925	286,925	26,558	12,461	16
17	15	Emp. Ben. - Healthcare	Patient Days	611,520		166,142		26,558	7,215	17
18	17	Administration Salary	Patient Days	611,520		891,091	891,091	26,558	38,700	18
19	21	Office Salary	Patient Days	611,520		55,009	55,009	26,558	2,389	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	611,520		156,720		26,558	6,806	20
21	10	Nursing / Medical Record Salary	Direct Allocation			10,300	10,300		121	21
22	12	Social Service / Admission Salary	Direct Allocation			6,057	6,057		597	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			2,077			73	23
24										24
25	TOTALS					$ 2,919,416	$ 2,090,347		$ 126,779	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 8,450	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						2,123	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 10,573	25

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

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						12,282	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					$	$		$ 12,282	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 125,043	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					$	$		$ 125,043	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	39	Ancillary Expense	Direct Allocation						29,255	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					$	$		$ 29,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
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: 01/01/12 Ending: 12/31/12

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	Note Payable			$	$ 4,500,000			$ 53,663	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Diawa Loan		X	Line of Credit				1,879,244			60,675	6
7	Fairfax Healthcare Properties		X					260,000			26,433	7
8	See Supplemental Schedule							1,082,177			45,091	8
9	TOTAL Facility Related						$	$ 7,721,421			$ 185,862	9
	B. Non-Facility Related*											
10	Allocated from ECConsulting										2,390	10
11	Allocated from ECClinical										15,801	11
12	Interest Income										(636)	12
13	See Supplemental Schedule										(74)	13
14	TOTAL Non-Facility Related						$	$			$ 17,481	14
15	TOTALS (line 9+line14)						$	$ 7,721,421			$ 203,343	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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: 01/01/12 Ending: 12/31/12

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Lemont Property	X					$	$ 1,082,177			$ 45,091	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							1,082,177			45,091	14
	B. Non-Facility Related*											
15	Interest Income - Bldg. Co.						$	$			$ (74)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(74)	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:** 01/01/12 **Ending:** 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 199,537	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.)		$ 177,891	2
3. Under or (over) accrual (line 2 minus line 1).		$ (21,646)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 185,189	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.**		$ 27,146	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** $ 96,655 **For** 2009 **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.		$ 190,689	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	181,917	8
	2008	241,978	9
	2009	281,966	10
	2010	190,035	11
	2011	176,370	12

2012 Accrual = 2011 Expense $176,370 + 5% = $185,189
Allocated from Extended Care Consulting $1,212
Allocated from Extended Care Clinical $309

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 176,370.05	$ 176,370.05
2.	See Attached	Home Office Allocation	$ 127,119.67	$ 1,208.44
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 303,489.72	$ 177,578.49

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

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: 01/01/12 Ending: 12/31/12

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).

None

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 2201 Main			7,795	2
3	TOTALS			$ 92,781	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	$ 2,541,100	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,222	1,222	21,095	9
10	Various			1996	82,791		20	4,140	4,140	69,250	10
11	Various			1997	44,854		20	2,243	2,243	34,800	11
12	Various			1998	47,497		20	2,271	2,271	35,892	12
13	Various			1999	39,389		20	1,969	1,969	27,027	13
14	Various			2000	13,995		20	700	700	8,716	14
15	Various			2001	20,621		20	1,031	1,031	12,048	15
16	Various			2002	8,353		20	229	229	7,290	16
17	Various			2003	20,578		20	1,556	1,556	14,923	17
18	Various			2004	61,438		20	5,338	5,338	51,551	18
19	Various			2005	140,855		20	13,971	13,971	97,505	19
20	Various			2006	29,295		20	2,398	2,398	18,063	20
21	Various			2007	102,339		20	7,166	7,166	75,865	21
22	Various			2008	86,109		20	5,541	5,541	56,648	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: 01/01/12 Ending: 12/31/12

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	1,131	67
68	Related Party Allocations (Pages 12H & 12I)		31,606	2,148		2,148		19,683	68
69	Financial Statement Depreciation			58,549			(58,549)		69
70	TOTAL (lines 4 thru 69)		$ 3,693,335	$ 137,043		$ 198,881	$ 61,838	$ 3,092,587	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: 01/01/12 Ending: 12/31/12

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		$ 3,693,335	$ 137,043		$ 198,881	$ 61,838	$ 3,092,587	1
2	Hvac Repairs	2009	23,976		20	2,398	2,398	8,392	2
3	Electrical Conduit Repair	2009	6,250		20	625	625	2,188	3
4	Plumbing Repairs	2009	5,300		20	530	530	1,723	4
5	Roof	2009	10,575		20	1,058	1,058	3,437	5
6	Refund Of Insurance Proceeds - Ceiling Cave In	2009	(5,392)		20	(539)	(539)	(2,157)	6
7	Landmark Adjustment - Ceiling	2009	(15,000)		20	(1,500)	(1,500)	(6,000)	7
8	Walk In Cooler	2009	3,066		20	307	307	945	8
9	Heat Sensors	2010	6,378		20	638	638	1,329	9
10	Piping	2010	2,565		20	128	128	374	10
11	Painting	2010	2,906		20	145	145	387	11
12	Flooring	2011	30,564		20	3,056	3,056	5,349	12
13	New Hvac Unit	2011	20,366		20	2,037	2,037	3,394	13
14	Sprinkler System Repair	2011	6,584		20	658	658	823	14
15	Roof	2011	54,600		20	5,460	5,460	6,370	15
16	Wall Guards	2011	4,995		20	999	999	1,998	16
17	Painting	2011	47,763		20	2,388	2,388	2,587	17
18	Sewer Piping	2012	7,000		20	583	583	583	18
19	Sewer Piping	2012	3,883		20	324	324	324	19
20	Signage	2012	3,200		20	240	240	240	20
21	Vinyl Flooring	2012	5,797		20	773	773	773	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)		$ 3,918,712	$ 137,043		$ 219,188	$ 82,145	$ 3,125,646	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: 01/01/12 Ending: 12/31/12

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		$ 3,918,712	$ 137,043		$ 219,188	$ 82,145	$ 3,125,646	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)		$ 3,918,712	$ 137,043		$ 219,188	$ 82,145	$ 3,125,646	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: 01/01/12 Ending: 12/31/12

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		$ 3,918,712	$ 137,043		$ 219,188	$ 82,145	$ 3,125,646	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)		$ 3,918,712	$ 137,043		$ 219,188	$ 82,145	$ 3,125,646	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: 01/01/12 Ending: 12/31/12

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		$ 3,918,712	$ 137,043		$ 219,188	$ 82,145	$ 3,125,646	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)		$ 3,918,712	$ 137,043		$ 219,188	$ 82,145	$ 3,125,646	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: 01/01/12 Ending: 12/31/12

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	1,131	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: 01/01/12 Ending: 12/31/12

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
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 (12F & 12G lines 1 thru 33)		$ 7,149	$		$ 357	$ 357	$ 1,131	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: 01/01/12 Ending: 12/31/12

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		8,562	220	39	220		2,680	3
4	Allocated from Extended Care Clinical - 2201 Main		2,180	56	39	56		575	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting		90	4	20	4		27	9
10	Allocated from Extended Care Consulting		54	3	20	3		11	10
11	Allocated from Extended Care Consulting		525	26	20	26		79	11
12	Allocated from Extended Care Consulting		189	9	20	9		19	12
13	Allocated from Extended Care Consulting		62	3	20	3		3	13
14									14
15	Allocated from Extended Care Consulting - 2201 Main		7,073	646	20	646		5,824	15
16	Allocated from Extended Care Consulting - 2201 Main		8,336	762	20	762		6,863	16
17	Allocated from Extended Care Consulting - 2201 Main		414	44	20	44		281	17
18	Allocated from Extended Care Consulting - 2201 Main		75	4	20	4		15	18
19									19
20	Allocated from Extended Care Clinical - 2201 Main		1,800	165	20	165		1,483	20
21	Allocated from Extended Care Clinical - 2201 Main		2,122	194	20	194		1,747	21
22	Allocated from Extended Care Clinical - 2201 Main		105	11	20	11		72	22
23	Allocated from Extended Care Clinical - 2201 Main		19	1	20	1		4	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: 01/01/12 Ending: 12/31/12

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
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 (12H & 12I lines 1 thru 33)		$ 31,606	$ 2,148		$ 2,148	$	$ 19,683	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: 01/01/12 Ending: 12/31/12

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	$ 152,392	$ 1,578	$ 9,445	$ 7,867	10	$ 134,684	71
72	Current Year Purchases	6,750		788	788	10	788	72
73	Fully Depreciated Assets	404,407				10	404,407	73
74								74
75	TOTALS	$ 563,549	$ 1,578	$ 10,232	$ 8,654		$ 539,879	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 ECConsulting	2012	3,017	603	603		5	3,017	77
78		allocated from ECClinical	2012	2,231	355	355		5	213	78
79										79
80	TOTALS			$ 52,456	$ 958	$ 958	$		$ 38,638	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)	$ 4,627,498	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 139,579	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 230,379	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 90,800	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,704,162	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: 01/01/12 Ending: 12/31/12

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								5
6								6
7	TOTAL				$ **			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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 3,274 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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	$		$ 375,424	$		$ 375,424	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			162,807			162,807	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			329,867			329,867	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				253,578		253,578	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					(30,799)	223,820		193,021	13
14	TOTAL			$		$ 837,299	$ 477,398		$ 1,314,697	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:** 01/01/12 **Ending:** 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 **(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	$ 4,286	$ 157,740	1
2	Cash-Patient Deposits	34,184	34,184	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,596,509	1,596,509	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,588	151,588	6
7	Other Prepaid Expenses	6,327	6,327	7
8	Accounts Receivable (owners or related parties)	159,500	600,983	8
9	Other(specify): See Attached Schedule	179,474	192,638	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,131,868	$ 2,739,969	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		2,765,876	14
15	Leasehold Improvements, at Historical Cost	833,862	833,862	15
16	Equipment, at Historical Cost	403,553	573,526	16
17	Accumulated Depreciation (book methods)	(985,279)	(2,471,030)	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	295	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 252,431	$ 1,817,570	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,384,299	$ 4,557,539	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,590,899	$ 1,590,899	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,501	24,501	28
29	Short-Term Notes Payable	1,879,244	1,879,244	29
30	Accrued Salaries Payable	170,785	170,785	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,355	10,355	31
32	Accrued Real Estate Taxes(Sch.IX-B)	185,189	185,189	32
33	Accrued Interest Payable		341,791	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	539,780	180,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,400,753	$ 4,382,764	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,842,177	39
40	Mortgage Payable			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)**	$	$ 5,842,177	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,400,753	$ 10,224,941	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,016,454)	$ (5,667,402)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,384,299	$ 4,557,539	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,154,827)	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,154,825)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	138,371	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)**	$ 138,371	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)**	$ (2,016,454)	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: 01/01/12 Ending: 12/31/12

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,322,213	1
2	Discounts and Allowances for all Levels	(3,578,508)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,743,705	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,475,011	6
7	Oxygen	17,336	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,492,347	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	291,267	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,821	19
20	Radiology and X-Ray	11,500	20
21	Other Medical Services	150,980	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 502,568	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	636	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 636	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	104,516	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 104,516	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,843,772	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	886,363	31
32	Health Care	2,165,321	32
33	General Administration	1,504,499	33
	B. Capital Expense		
34	Ownership	662,097	34
	C. Ancillary Expense		
35	Special Cost Centers	1,314,767	35
36	Provider Participation Fee	172,354	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,705,401	40
41	**Income before Income Taxes (line 30 minus line 40)****	138,371	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 138,371	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,893,366	44
45	Private Pay - Net Inpatient Revenue	169,316	45
46	Medicare - Net Inpatient Revenue	(479,333)	46
47	Other-(specify) Hospice	180,602	47
48	Other-(specify) Insurance	(20,246)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,743,705	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,989	2,070	$ 88,624	$ 42.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,133	10,451	315,335	30.17	3
4	Licensed Practical Nurses	21,870	23,334	608,314	26.07	4
5	CNAs & Orderlies	48,540	52,997	542,787	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,634	7,902	126,541	16.01	8
9	Activity Director	2,022	2,126	34,685	16.31	9
10	Activity Assistants	7,145	7,686	69,033	8.98	10
11	Social Service Workers	6,669	6,954	189,394	27.24	11
12	Dietician					12
13	Food Service Supervisor	2,013	2,306	52,117	22.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,896	15,585	169,758	10.89	15
16	Dishwashers					16
17	Maintenance Workers	3,266	3,639	65,991	18.13	17
18	Housekeepers	9,655	10,489	116,354	11.09	18
19	Laundry	4,734	5,188	68,132	13.13	19
20	Administrator	2,015	2,254	92,673	41.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,198	6,692	88,193	13.18	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	1,675	1,923	31,516	16.39	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,824	2,155	32,232	14.96	33
34	TOTAL (lines 1 - 33)	149,278	163,751	$ 2,691,679 *	$ 16.44	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	312	$ 14,247	01-03	35
36	Medical Director	monthly	16,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,596	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	Various - See Attached		718		47
48					48
49	TOTAL (lines 35 - 48)	312	$ 36,061		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Elkaim	Administrator	0	$ 92,673
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,673

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	$ 30,218
Pinnacle Quality Insight	Customer Satisfaction	2,390
DJN Organizational Consult.	Customer Service Training	500
Legat Architects	Architect	431
Mctique & Associates	Plat of Survey	1,650
Prospect Resources	Natural Gas Procurement	1,842
Hamlin & Burton Liability	Liability Insurance Services	1,774
Personnel Planners	Unemployment Consult	3,755
HFG	Line of Credit Fees	7,810
Extended Care Consulting	Home Office Expense	171,792
Extended Care Clinical	Home Office Expense	84,612
See Supplemetal Schedule		72,404
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 379,178

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,975
Unemployment Compensation Insurance	133,969
FICA Taxes	203,433
Employee Health Insurance	144,258
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	3,043
Pension Expense	21,221
Other Employee Benefits	3,623
Holiday Expense	1,655
TOTAL (agree to Schedule V, line 22, col.8)	$ 603,177

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	$ 1,999
Advertising: Employee Recruitment	1,133
Health Care Worker Background Check	
(Indicate # of checks performed 25)	947
Patient Background Checks	
Licenses & Fees	3,131
Dues & Subscriptions	6,401
Advertising & Promotion	6,087
Allocated from ECConsulting	2,005
See Supplemental Schedule	54
Less: Public Relations Expense	( )
Non-allowable advertising	(6,087)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,670

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,679
Allocated from ECConsulting	123
Allocated from ECClinical	836
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,638

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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:** 01/01/12 **Ending:** 12/31/12

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. **ICLTC $7,350**

(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?

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,007** 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.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **172,354**
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. $ **0** 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% ln. 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(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.