FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: 0055400

Facility Name: Tri State Village Nrsg Rhb

Address: 2500 East 175th St (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: 2018

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Joshua S. Banach **Telephone Number:** (874) 628-8784
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 1/1/20 to 12/31/20 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) Denise A Leonard, CPA, Partner
(Firm Name & Address) Plante & Moran, 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
(Telephone) (216) 274-6514 Fax # (248) 233-7349

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	9,544	351	5,682	15,577	8
9	SNF/PED					9
10	ICF	7,855	218		8,073	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,399	569	5,682	23,650	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.93%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 4,374

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	302,549	47,151	11,823	361,523		361,523		361,523			1
2	Food Purchase		147,277		147,277		147,277		147,277			2
3	Housekeeping	152,596	22,188		174,784		174,784		174,784			3
4	Laundry	81,505	13,977		95,482		95,482		95,482			4
5	Heat and Other Utilities			85,701	85,701		85,701	(9,151)	76,550			5
6	Maintenance	91,920	35,757	7,974	135,651		135,651	(3,510)	132,141			6
7	Other (specify):*			25,171	25,171		25,171		25,171			7
8	TOTAL General Services	628,570	266,350	130,669	1,025,589		1,025,589	(12,661)	1,012,928			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,289,069	231,474	128,959	2,649,502		2,649,502		2,649,502			10
10a	Therapy	122,915		728,548	851,463		851,463		851,463			10a
11	Activities	141,369	10,745		152,114		152,114		152,114			11
12	Social Services	173,127	1,014	796	174,937		174,937		174,937			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,726,480	243,233	876,303	3,846,016		3,846,016		3,846,016			16
	C. General Administration											
17	Administrative	100,507			100,507		100,507		100,507			17
18	Directors Fees											18
19	Professional Services			618,683	618,683		618,683	(289,032)	329,651			19
20	Dues, Fees, Subscriptions & Promotions			23,276	23,276		23,276	(6,545)	16,731			20
21	Clerical & General Office Expenses	207,666	33,035	43,242	283,943		283,943	(18,965)	264,978			21
22	Employee Benefits & Payroll Taxes			623,171	623,171		623,171		623,171			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,385	2,385		2,385		2,385			24
25	Other Admin. Staff Transportation			10,928	10,928		10,928		10,928			25
26	Insurance-Prop.Liab.Malpractice			183,028	183,028		183,028		183,028			26
27	Other (specify):*			22,063	22,063		22,063	(22,063)				27
28	TOTAL General Administration	308,173	33,035	1,526,776	1,867,984		1,867,984	(336,605)	1,531,379			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,663,223	542,618	2,533,748	6,739,589		6,739,589	(349,266)	6,390,323			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tri State Village Nrsg Rhb #0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			16,649	16,649		16,649	60,618	77,267			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,709	27,709		27,709	65,243	92,952			32
33	Real Estate Taxes			549,818	549,818		549,818		549,818			33
34	Rent-Facility & Grounds			473,086	473,086		473,086	(469,298)	3,788			34
35	Rent-Equipment & Vehicles			13,590	13,590		13,590		13,590			35
36	Other (specify):*			2,728	2,728		2,728	(2,728)				36
37	**TOTAL Ownership**			1,083,580	1,083,580		1,083,580	(346,165)	737,415			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,255	109,777	137,032		137,032		137,032			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,713	166,713		166,713		166,713			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		27,255	276,490	303,745		303,745		303,745			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,663,223	569,873	3,893,818	8,126,914		8,126,914	(695,431)	7,431,483			45

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Reference	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	(9,151)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(47,168)	30		9
10	Interest and Other Investment Income	(769)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(481)	36		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	(13,653)	21		18
19	Entertainment				19
20	Contributions	(500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,563)	27		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	(66,798)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,083)		$	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)	(535,348)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (535,348)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (695,431)		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

Tri State Village Nrsg Rhb

ID# 0055400

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lansing HC Properties Management Fees	$ (6,300)	17	1
2	Lansing HC Properties Accounting Fees	(2,450)	19	2
3	Lansing HC Properties Bank Charges & Admin	(649)	21	3
4	Lansing HC Properties Amortization	(13,304)	31	4
5	Bank Charges	(1,398)	21	5
6	Collection Expense	(891)	21	6
7	Settlement Expense	(3,075)	19	7
8	Theft Loss	(573)	21	8
9	Amortization	(2,247)	36	9
10	Non-Allowable Real Estate (Vacant Land)	(16,478)	33	10
11	Non-Allowable Expense	(2,703)	21	11
12	Capitalized R&M	(3,510)	06	12
13	PPP Consulting	(3,600)	19	13
14	Non-Allowable Legal	(3,075)	19	14
15	PAC Dues	(6,545)	20	15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(66,798)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,510)	0	0	0	0	0	0	0	0	0	0	(3,510)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,510)	0	0	0	0	0	0	0	0	0	0	(3,510)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(6,300)	6,300	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,200)	2,450	(279,282)	0	0	0	0	0	0	0	0	(289,032)	19
20	Fees, Subscriptions & Promotions	(6,545)	0	0	0	0	0	0	0	0	0	0	(6,545)	20
21	Clerical & General Office Expenses	(6,214)	648	253	0	0	0	0	0	0	0	0	(5,313)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,259)	9,398	(279,029)	0	0	0	0	0	0	0	0	(300,890)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,769)	9,398	(279,029)	0	0	0	0	0	0	0	0	(304,400)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri State Village Nrsg Rhb **#** 0055400 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(47,168)	107,786	0	0	0	0	0	0	0	0	0	60,618	30
31	Amortization of Pre-Op. & Org.	(13,304)	13,304	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	66,011	0	0	0	0	0	0	0	0	0	66,011	32
33	Real Estate Taxes	(16,478)	16,478	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(473,086)	3,788	0	0	0	0	0	0	0	0	(469,298)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(2,247)	0	0	0	0	0	0	0	0	0	0	(2,247)	36
37	TOTAL Ownership	(79,197)	(269,507)	3,788	0	0	0	0	0	0	0	0	(344,916)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(113,966)	(260,109)	(275,241)	0	0	0	0	0	0	0	0	(649,316)	45

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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	$ 473,086	Lansing Healthcare Properties	100.00%	$	$ (473,086)	1
2	V	33	Real Estate Taxes	401,942	Lansing Healthcare Properties	100.00%	418,420	16,478	2
3	V	32	Interest	88,899	Lansing Healthcare Properties	100.00%	154,910	66,011	3
4	V	17	Management Fees		Lansing Healthcare Properties	100.00%	6,300	6,300	4
5	V	19	Legal & Accounting		Lansing Healthcare Properties	100.00%	2,450	2,450	5
6	V	21	A&G Expenses & Fees		Lansing Healthcare Properties	100.00%	648	648	6
7	V	30	Depreciation		Lansing Healthcare Properties	100.00%	107,786	107,786	7
8	V	31	Amortization		Lansing Healthcare Properties	100.00%	13,304	13,304	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 963,927			$ 703,818	$ * (260,109)	14

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Rita Lipshitz	25.00%	Wheaton Village Nursing & Rehab	Wheaton, IL	Lansing HC Property	Lansing, IL	Building Co	1
2	David Mashiash	25.00%	Little Village Nursing & Rehab	Chicago, IL	Jade Financial	Chicago, IL	Consulting Co	2
3	Jake Mashiach	25.00%	Kensington Place Nursing & Rehab	Chicago, IL				3
4	Rhonda Mashiach	25.00%	Sheridan Village Nursing & Rehab	Chicago, IL				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 Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	21	A&G Expenses	$	Jade Financial	100.00%	$ 253	$ 253	15
16	V	19	Professional Fees	279,569	Jade Financial	100.00%	287	(279,282)	16
17	V	34	Rent Expense		Jade Financial	100.00%	3,788	3,788	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			$ 279,569			$ 4,328	$ * (275,241)	39

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Yechiel Mashiash	Owner	Administrative	25.00%	See Attached	0.54	1.35%	Salary	$ 2,703	17-1	1
2	Yaacov Mashiash	Owner	Admin/Admisison	25.00%	See Attached	3.72	9.29%	Salary	10,056	17-1; 12-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,759		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 Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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: Jade Financial Services LLC
Street Address: 2320 S. Lawndale Ave
City / State / Zip Code: Chicago, Illinois 60623
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	21	A&G Expenses	Resident Days	200,733	5	$ 2,146	$	23,650	$ 253	1
2	19	Professional Fees	Resident Days	200,733	5	2,435		23,650	287	2
3	34	Rent Expense	Resident Days	200,733	5	32,153		23,650	3,788	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					$ 36,734	$		$ 4,328	25

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	CIBC		X	Revolving Note (Bldg)			$	$ 3,000,000			$ 88,899	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit				242,289			27,709	6
7	Lemont Property		X	Working Capital				1,082,177			66,013	7
8	Shareholder Loan	X		Working Capital				353,212				8
9	TOTAL Facility Related						$	$ 4,677,678			$ 182,621	9
	B. Non-Facility Related*											
10	Interest Income		X								(769)	10
11	Interest Income- Bldg		X								(88,899)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (89,668)	14
15	TOTALS (line 9+line14)						$	$ 4,677,678			$ 92,953	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

** 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 Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 406,322	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.)		$ 541,351	2
3. Under or (over) accrual (line 2 minus line 1).		$ 135,029	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 413,989	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.)		$ 800	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 549,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	257,036	8
	2016	276,634	9
	2017	390,741	10
	2018	386,973	11
	2019	394,275	12

2020 Accrual = $394,275 X 1.05 = $413,989

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri State Village Nrsg Rhb COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055400

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (874) 628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 394,275.08	$ 394,275.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 394,275.08	$ 394,275.08

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 [ ] (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		1995	$ 98,212	1
2					2
3	TOTALS			$ 98,212	3

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		1995	1962	$ 2,932,035	$	40	$ 73,301	$ 73,301	$ 1,905,823	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	RTU Repairs-PT Room- New Blower Assembly			2019	2,544		20	127	127	254	9
10	Fire Sprinkler System Repair- Dry Pendant Heads			2019	14,619		20	731	731	1,462	10
11	Fire Sprinkler System Repair- Sprinkler Heads Replacement			2019	28,976		20	1,449	1,449	2,898	11
12	Replacement of Ceiling in the Main Lobby			2020	29,688		20	1,484	1,484	1,484	12
13	Repairs to Walk In Freezer- Evaporator & Coils			2020	3,510		20	176	176	176	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	Financial Statement Depreciation- Tri-State Village Nursing & Rehab					16,650			(16,650)		31
32	Financial Statement Depreciation- Lansing HC Properties					107,786			(107,786)		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 Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	70

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12E, Carried Forward		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12F, Carried Forward		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12G, Carried Forward		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	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)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12H, Carried Forward		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 3,011,372	$ 124,436		$ 77,268	$ (47,168)	$ 1,912,096	34

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Attached	169,973					169,973	74
75	TOTALS	$ 169,973	$	$	$		$ 169,973	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,279,557	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 124,436	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,268	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (47,168)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,082,069	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	Section 754 Costs	$ 62,293	$	$ 62,293	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 62,293	$	$ 62,293	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 Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Allocated From Jade Financial				3,788			5
6								6
7	TOTAL				$ 3,788 **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 5,168 Description: $2,319 Copiers; $1,832 Dishwasher; $1,017 Postage Machine
(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	Facility	GM	$ 701.79	$ 8,422	17
18					18
19					19
20					20
21	TOTAL		$ 701.79	$ 8,422	21

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

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	$	4,909	$ 368,210	$	4,909	$ 368,210	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,134	85,068		1,134	85,068	2
3	Licensed Recreational Therapist	V10A	hrs			0				3
4	Licensed Physical Therapist	V10A	hrs		3,670	275,270		3,670	275,270	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	122,915			271		123,186	8
9	Pharmacy	V39	# of prescrpts				98,602		98,602	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					10,904		10,904	12
13	Other (specify): BILLABLE SUPPLIES	V39					7,717		7,717	13
14	TOTAL			$ 122,915	9,714	$ 728,548	$ 117,494	9,714	$ 968,957	14

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 805,924	$ 924,379	1
2	Cash-Patient Deposits	40,376	40,376	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,405,436	2,405,436	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,162	92,162	6
7	Other Prepaid Expenses	3,411	3,411	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	116,355	218,972	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,463,664	$ 3,684,736	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		2,977,499	14
15	Leasehold Improvements, at Historical Cost	73,284	73,284	15
16	Equipment, at Historical Cost	2,544	172,517	16
17	Accumulated Depreciation (book methods)	(18,430)	(2,910,099)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,117	33,726	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(18,848)	20
21	Restricted Funds	399,977	399,977	21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached	109,242	4,474,242	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 573,734	$ 5,317,339	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,037,398	$ 9,002,075	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 742,176	$ 742,176	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,868	35,868	28
29	Short-Term Notes Payable	439,745	3,439,745	29
30	Accrued Salaries Payable	262,574	262,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,921	7,921	31
32	Accrued Real Estate Taxes(Sch.IX-B)	413,989	413,989	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	1,179,678	1,683,655	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,081,951	$ 6,585,928	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,082,177	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	381,886	381,886	43
44	See Attached	1,000	1,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 382,886	$ 1,465,063	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,464,837	$ 8,050,991	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 572,561	$ 951,084	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,037,398	$ 9,002,075	48

***(See instructions.)**

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 192,080	1	
2	Restatements (describe):		2	
3	**Prior Year RE Adjustment & Other Entries**	95,376	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 287,456	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	285,105	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)**	$ 285,105	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)**	$ 572,561	24	*

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 7,361,593	1
2	Discounts and Allowances for all Levels	(2,543,171)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,818,422	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,479,387	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,479,387	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	94,805	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,765	19
20	Radiology and X-Ray	5,415	20
21	Other Medical Services	9,753	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 123,738	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	769	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 769	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		989,703	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 989,703	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,412,019	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,025,589	31
32	Health Care	3,846,016	32
33	General Administration	1,867,984	33
	B. Capital Expense		
34	Ownership	1,083,580	34
	C. Ancillary Expense		
35	Special Cost Centers	137,032	35
36	Provider Participation Fee	166,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,126,914	40
41	**Income before Income Taxes (line 30 minus line 40)****	285,105	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 285,105	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,795,275	44
45	Private Pay - Net Inpatient Revenue	81,610	45
46	Medicare - Net Inpatient Revenue	1,076,789	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	228,775	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(364,027)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,818,422	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.**

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	2,071	3,595	$ 197,045	$ 54.81	1
2	Assistant Director of Nursing	546	629	24,451	38.87	2
3	Registered Nurses	5,947	7,961	332,468	41.76	3
4	Licensed Practical Nurses	23,542	26,622	884,440	33.22	4
5	CNAs & Orderlies	37,364	44,489	742,220	16.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,658	6,513	122,915	18.87	8
9	Activity Director	1,818	2,059	36,677	17.81	9
10	Activity Assistants	5,866	6,945	104,692	15.07	10
11	Social Service Workers	5,998	6,757	173,127	25.62	11
12	Dietician					12
13	Food Service Supervisor	1,921	2,092	55,458	26.51	13
14	Head Cook	13,460	14,842	247,091	16.65	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,630	4,070	91,920	22.58	17
18	Housekeepers	8,313	9,600	152,596	15.90	18
19	Laundry	3,850	4,630	81,505	17.60	19
20	Administrator	1,776	2,017	100,507	49.83	20
21	Assistant Administrator					21
22	Other Administrative	10,594	11,442	282,038	24.65	22
23	Office Manager					23
24	Clerical					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	1,652	2,034	34,073	16.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,006	156,297	$ 3,663,223 *	$ 23.44	34

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

** See instructions.

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	192	$ 11,823	V01-03	35
36	Medical Director	Monthly Fees	18,000	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	4,973	V10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		271	V39-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly Fees	146	V12-03	45
46	Other(specify)				46
47	Psycho-Social Consultant	4	650	V12-03	47
48					48
49	TOTAL (lines 35 - 48)	196	$ 35,863		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	558	$ 64,134	V10-03	50
51	Licensed Practical Nurses	555	48,866	V10-03	51
52	Certified Nurse Assistants/Aides	177	8,972	V10-03	52
53	TOTAL (lines 50 - 52)	1,289	$ 121,972		53

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Elkaim	Administrator	0.00%	$ 93,804
Yechiel Mashiach	Administrator	25.00%	2,703
Yaacov Mashiach	Administrator	25.00%	4,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,507

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
Ability Network	Data Processing/Billing	$ 9,047
IIT Sourcetech	IT Consulting	440
Matrixcare	Data Processing/Software	20,910
National Datacare	Resident Funds Mgmt	1,075
Paycor / Propay	Payroll Processing	16,978
See Attached	Legal Services	6,612
Skidelsky & Associates	Real Estate Tax Appeal	800
Plante Moran	Accounting Services	24,000
Personnel Planners	Unemployment Consulting	1,824
Benefit CT Corp	Emp. Benefit Consulting	476
RLC	Healthcare Consulting	3,120
See Supplemental Page 21		533,402
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 618,683

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,632
Unemployment Compensation Insurance	19,189
FICA Taxes	267,553
Employee Health Insurance	195,308
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	1,718
Other Employee Welfare	11,485
Pension Expense	57,286
TOTAL (agree to Schedule V, line 22, col.8)	$ 623,171

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,704
Advertising: Employee Recruitment	1,145
Health Care Worker Background Check	486
(Indicate # of checks performed 48)	
Patient Background Checks	
Licenses & Fees	2,120
Dues & Subscriptions	11,276
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,731

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,385
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,385

**See instructions.

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1) $
(List each licensed administrator separately.)

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
GCHMO	Managed Care Consulting	$ 74,338
Sher LLP	PPP Loan Consulting (ADJ)	3,600
Legat Architects	Architecture Services	1,623
Terrill Consulting	AR Consulting	45,487
ECC Consulting	Consulting Fees	128,784
Jade Financial	Consulting Fees	279,569

TOTAL (agree to Schedule V, line 19, column 3) $ 533,402
(For legal fee disclosure, see page 39 of instructions)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

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

Description	Line #	Amount
		$

TOTAL $

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

**See instructions.

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 1/1/20 Ending: 12/31/20

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. **Healthcare Council of IL $13,091**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,264** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **166,713**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln1**
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: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.