

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0041186

Facility Name: Tri-State Nursing & Rehab Ctr

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

County: Cook

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

HFS ID Number: 364034144001

Date of Initial License for Current Owners: 9/1/1995

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____
Paid Preparer	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>19,182</u>	<u>2,649</u>	<u>5,909</u>	<u>27,740</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,182</u>	<u>2,649</u>	<u>5,909</u>	<u>27,740</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.48%

D. How many bed-hold days during this year were paid by the Department?

3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 09/01/95

J. Was the facility purchased or leased after January 1, 1978?

YES Date 09/01/95 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 56 and days of care provided 3,252

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	200,765	26,394	8,641	235,800		235,800	(67)	235,733		1
2	Food Purchase		127,833		127,833		127,833	(83)	127,750		2
3	Housekeeping	111,593	23,533		135,126		135,126	(1,634)	133,492		3
4	Laundry	91,438	12,376		103,814		103,814		103,814		4
5	Heat and Other Utilities			100,334	100,334		100,334	1,604	101,938		5
6	Maintenance	57,911		114,937	172,848		172,848	7,372	180,220		6
7	Other (specify):*							9,237	9,237		7
8	TOTAL General Services	461,707	190,136	223,912	875,755		875,755	16,429	892,184		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,438,397	60,012	3,830	1,502,239		1,502,239	6,028	1,508,267		10
10a	Therapy	144,532		4,764	149,296		149,296	1,239	150,535		10a
11	Activities	85,271	8,946	1,575	95,792		95,792		95,792		11
12	Social Services	93,413	128	859	94,400		94,400	3,563	97,963		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,341	2,341		15
16	TOTAL Health Care and Programs	1,761,613	69,086	20,028	1,850,727		1,850,727	13,171	1,863,898		16
	C. General Administration										
17	Administrative	69,739		24,154	93,893		93,893	7,488	101,381		17
18	Directors Fees										18
19	Professional Services			199,081	199,081		199,081	(162,710)	36,371		19
20	Dues, Fees, Subscriptions & Promotions			34,570	34,570		34,570	(10,112)	24,458		20
21	Clerical & General Office Expenses	69,120	13,173	235,658	317,951		317,951	(98,527)	219,424		21
22	Employee Benefits & Payroll Taxes			384,721	384,721		384,721	(5,674)	379,047		22
23	Inservice Training & Education			3,353	3,353		3,353		3,353		23
24	Travel and Seminar			554	554		554	258	812		24
25	Other Admin. Staff Transportation			4,882	4,882		4,882	894	5,776		25
26	Insurance-Prop.Liab.Malpractice			79,847	79,847		79,847	1,129	80,976		26
27	Other (specify):*							19,752	19,752		27
28	TOTAL General Administration	138,859	13,173	966,820	1,118,852		1,118,852	(247,502)	871,350		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,362,179	272,395	1,210,760	3,845,334		3,845,334	(217,902)	3,627,432		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr #0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			71,053	71,053	71,053	159,688	230,741			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			4,927	4,927	4,927	133,549	138,476			32
33	Real Estate Taxes			178,168	178,168	178,168	1,394	179,562			33
34	Rent-Facility & Grounds			337,260	337,260	337,260	(335,449)	1,811			34
35	Rent-Equipment & Vehicles			3,377	3,377	3,377	294	3,671			35
36	Other (specify):*										36
37	TOTAL Ownership			594,785	594,785	594,785	(40,524)	554,261			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		233,483	198,939	432,422	432,422	(17,778)	414,644			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			45,990	45,990	45,990		45,990			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		233,483	244,929	478,412	478,412	(17,778)	460,634			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,362,179	505,878	2,050,474	4,918,531	4,918,531	(276,204)	4,642,327			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	71,349	30		9
10	Interest and Other Investment Income	(14,582)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(122)	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	(7,280)	21		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,141)	21		24
25	Fund Raising, Advertising and Promotional	(11,936)	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	(40,476)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (144,288)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(131,916)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (131,916)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (276,204)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Miscellaneous Income	(10,174) 21 1
2	Vending Income	(184) 62 2
3	Theft Loss	(57) 21 3
4	Collection Expense	(524) 21 4
5	COPY Dues	999 20 5
6	Annual Report	(250) 20 6
7	Non-Allowable Expense	(24,000) 21 7
8	Prior Period & Out of State Seminar	(250) 24 8
9	Prior Period Legal	(1,000) 19 9
10	Assisted Living Parcel - Real Estate Taxes	(2,750) 33 10
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101	Total	(40,476) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

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			116	1,650	(1,900)		67					(67)	1
2	Food Purchase	(226)		143									(83)	2
3	Housekeeping			219	22	18		(1,893)					(1,634)	3
4	Laundry													4
5	Heat and Other Utilities			1,042	56	506							1,604	5
6	Maintenance			6,892	7	206	311	(44)					7,372	6
7	Other (specify):*			9,080	157								9,237	7
8	TOTAL General Services	(226)		17,492	1,892	(1,170)	311	(1,870)					16,429	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				12,840	(2,953)		(3,859)					6,028	10
10a	Therapy				1,239								1,239	10a
11	Activities													11
12	Social Services				3,573			(10)					3,563	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,341								2,341	15
16	TOTAL Health Care and Programs				19,993	(2,953)		(3,869)					13,171	16
	C. General Administration													
17	Administrative			4,973	(1,634)	4,149							7,488	17
18	Directors Fees													18
19	Professional Services	(1,098)		(157,630)	(4,037)	55							(162,710)	19
20	Fees, Subscriptions & Promotions	(13,285)		3,003	14	314		(158)					(10,112)	20
21	Clerical & General Office Expenses	(183,176)		73,205	5,829	6,952	(1,337)						(98,527)	21
22	Employee Benefits & Payroll Taxes			(5,564)	(110)								(5,674)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(520)		508	270								258	24
25	Other Admin. Staff Transportation			657		237							894	25
26	Insurance-Prop.Liab.Malpractice			666	7	456							1,129	26
27	Other (specify):*			14,268	3,828	1,656							19,752	27
28	TOTAL General Administration	(198,079)		(65,914)	4,167	13,819	(1,337)	(158)					(247,502)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(198,305)		(48,422)	26,052	9,696	(1,026)	(5,897)					(217,902)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	71,349	76,346	8,495	357	357	2,784						159,688	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,582)	129,304	16,029	1,536	595	667						133,549	32
33	Real Estate Taxes	(2,750)	2,750	1,243	84	67							1,394	33
34	Rent-Facility & Grounds		(337,260)	1,343		468							(335,449)	34
35	Rent-Equipment & Vehicles			177	3	114							294	35
36	Other (specify):*													36
37	TOTAL Ownership	54,017	(128,860)	27,287	1,980	1,601	3,451						(40,524)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(8,342)	(7,800)	(1,636)					(17,778)	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					(8,342)	(7,800)	(1,636)					(17,778)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(144,288)	(128,860)	(21,135)	28,032	2,955	(5,375)	(7,533)					(276,204)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lansing Healthcare Properties		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 337,260	Lansing Healthcare Properties	100.00%	\$	\$ (337,260)	1
2	V	33 Real Estate Taxes	178,168			180,918	2,750	2
3	V	32 Interest				129,304	129,304	3
4	V	30 Depreciation				76,346	76,346	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 515,428			\$ 386,568	\$ * (128,860)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary		Care Centers, Inc.	100.00%	\$ 116	\$ 116	15	
16	V	02	Food		Care Centers, Inc.	100.00%	143	143	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	219	219	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	1,042	1,042	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	1,718	1,718	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	1,041	1,041	20	
21	V	19	Professional Fees	163,124	Care Centers, Inc.	100.00%	5,494	(157,630)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	3,003	3,003	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	8,702	8,702	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	508	508	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	657	657	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	666	666	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	8,495	8,495	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	16,029	16,029	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,243	1,243	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	1,343	1,343	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	177	177	31	
32	V	06	Maintenance	58,438	Care Centers, Inc.	100.00%	63,612	5,174	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	9,080	9,080	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	3,932	3,932	34	
35	V	21	Office and Clerical	33,185	Care Centers, Inc.	100.00%	97,688	64,503	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	14,268	14,268	36	
37	V	22	Employee Benefits	5,564	Care Centers, Inc.	100.00%		(5,564)	37	
38	V								38	
39	Total			\$ 260,311			\$ 239,176	\$ * (21,135)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 22	\$ 22	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	56	56	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	7	7	17	
18	V	19	Professional Fees	4,976	Care Centers Clinical, Inc.	100.00%	939	(4,037)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	14	14	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	55	55	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	270	270	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	7	7	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	357	357	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	1,536	1,536	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	84	84	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	3	3	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	1,650	1,650	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	157	157	28	
29	V	10	Nursing Salary	588	Care Centers Clinical, Inc.	100.00%	13,428	12,840	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,239	1,239	30	
31	V	12	Social Service Salary	144	Care Centers Clinical, Inc.	100.00%	3,717	3,573	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	2,341	2,341	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	22,520	22,520	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	5,774	5,774	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	3,828	3,828	35	
36	V	22	Employee Benefits	110	Care Centers Clinical, Inc.	100.00%		(110)	36	
37	V								37	
38	V	17	Management Fees	24,154	Care Centers Clinical, Inc.	100.00%		(24,154)	38	
39	Total			\$ 29,972			\$ 58,004	\$ * 28,032	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr# 0041186Report Period Beginning: 01/01/07Ending: 12/31/07

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 2,525	\$ 2,525	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	18	18	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	506	506	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	206	206	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	55	55	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	314	314	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,084	1,084	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	237	237	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	456	456	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	357	357	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	595	595	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	67	67	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	468	468	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	114	114	28	
29	V	01	Dietary	6,588	Care Centers Health Systems, Inc.	100.00%	2,163	(4,425)	29	
30	V	02	Food		Care Centers Health Systems, Inc.	100.00%			30	
31	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			31	
32	V	10	Nursing	4,396	Care Centers Health Systems, Inc.	100.00%	1,443	(2,953)	32	
33	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33	
34	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34	
35	V	39	Ancillary	12,419	Care Centers Health Systems, Inc.	100.00%	4,077	(8,342)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	4,149	4,149	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	5,868	5,868	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,656	1,656	38	
39	Total			\$ 23,403			\$ 26,358	\$ *	2,955	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 311	\$ 311	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	2,448	2,448	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	205	205	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	336	336	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	462	462	20
21	V	21	Office and Clerical	1,337	Vent Lease, LLC.	100.00%		(1,337)	21
22	V	39	Ancillary	7,800	Vent Lease, LLC.	100.00%		(7,800)	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			\$ 9,137			\$ 3,762	\$ * (5,375)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$ (839)	Xcel Supply, LLC	100.00%	\$ (772)	\$ 67	15
16	V	3 Housekeeping	23,468	Xcel Supply, LLC	100.00%	21,575	(1,893)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance	546	Xcel Supply, LLC	100.00%	502	(44)	18
19	V	10 Nursing	47,856	Xcel Supply, LLC	100.00%	43,997	(3,859)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service	128	Xcel Supply, LLC	100.00%	118	(10)	21
22	V	20 Dues, Fees And Subscriptions	1,959	Xcel Supply, LLC	100.00%	1,801	(158)	22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	20,290	Xcel Supply, LLC	100.00%	18,654	(1,636)	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		\$ 93,408			\$ 85,875	\$ * (7,533)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 78,910	\$ 78,910	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	78,910	CCS Employee Benefits Group	100.00%		(78,910)	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			\$ 78,910			\$ 78,910	\$ *	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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 Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.19%	See Attached	0.57	1.23%		\$	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	0.94	1.70%	Alloc. Salary	2,306	17-7	2
3	Adam Vales	Owner	Clerical	4.76%	See Attached	0.49	1.22%	Alloc. Salary	679	22-7	3
4	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.43	1.22%	Alloc. Salary	374	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,359		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 27,740	\$ 116	1
2	2	Food	Patient Days	1,625,640	33	8,403	27,740	143	2
3	3	Housekeeping	Patient Days	1,625,640	33	12,807	27,740	219	3
4	5	Utilities	Patient Days	1,625,640	33	61,054	27,740	1,042	4
5	6	Maintenance	Patient Days	1,625,640	33	100,693	27,740	1,718	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	27,740	1,041	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	27,740	5,494	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	27,740	3,003	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	27,740	8,702	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	27,740	508	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	27,740	657	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	27,740	666	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	27,740	8,495	13
14	32	Interest	Patient Days	1,625,640	33	939,326	27,740	16,029	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	27,740	1,243	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	27,740	1,343	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	27,740	177	17
18	6	Maintenance	Patient Days	1,625,640	33	187,019	187,019	3,191	18
19	6	Maintenance	Direct Allocation			456,812	456,812	60,421	19
20	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	27,740	9,080	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	3,932	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	64,494	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	33,194	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	27,740	14,268	24
25	TOTALS					\$ 8,891,187	\$ 5,143,113	\$ 239,176	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Care Center Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 27,740	\$ 22	1	
2	5	Utilities	Patient Days	1,625,640	32	3,307	27,740	56	2	
3	6	Maintenance	Patient Days	1,625,640	32	410	27,740	7	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	27,740	939	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	27,740	14	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	27,740	55	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	27,740	270	7	
8	26	Insurance	Patient Days	1,625,640	32	409	27,740	7	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	27,740	357	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	27,740	1,536	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	27,740	84	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	27,740	3	12	
13	1	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	27,740	1,650	13
14	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	27,740	157	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	27,740	12,820	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	27,740	1,239	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	27,740	3,559	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	27,740	2,272	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	27,740	22,520	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	27,740	5,774	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	27,740	3,828	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		608	22
23	12	Social Service Salary	Direct Allocation			8,845	8,845		158	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			69	24
25	TOTALS					\$ 3,374,560	\$ 2,809,548	\$ 58,004	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Care Centers Health Systems, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Gross Billable Income	4,431,674	33	94,358	118,607	2,525	1	
2	3	Housekeeping	Gross Billable Income	4,431,674	33	663	118,607	18	2	
3	5	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	118,607	506	3	
4	6	Maintenance	Gross Billable Income	4,431,674	33	7,696	118,607	206	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	118,607	55	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	118,607	314	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	118,607	1,084	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	118,607	237	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	118,607	456	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	118,607	357	10	
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	118,607	595	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	118,607	67	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	118,607	468	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	118,607	114	14	
15	1	Dietary	Direct Billable Income	341,879	33	112,243	6,588	2,163	15	
16	2	Food	Direct Billable Income	25	33	8			16	
17	3	Housekeeping	Direct Billable Income	29	33	10			17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856	4,396	1,443	18	
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20	
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	12,419	4,077	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	118,607	4,149	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	118,607	5,868	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	118,607	1,656	24	
25	TOTALS					\$ 2,152,813	\$ 374,301	\$ 26,358	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Repairs	Direct Billing	892,186	27	\$ 35,557	\$ 7,800	\$ 311	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	7,800		2
3	30	Depreciation	Direct Billing	892,186	27	280,000	7,800	2,448	3
4	32	Interest	Direct Billing	892,186	27	23,404	7,800	205	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	27,740	336	5
6	32	Interest	Patient Days	1,625,640	33	27,081	27,740	462	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					\$ 385,763	\$	\$ 3,762	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		(772)	1
2	3	Housekeeping	Direct Allocation					21,575	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation					502	4
5	10	Nursing	Direct Allocation					43,997	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation					118	7
8	20	Dues, Fees And Subscriptions	Direct Allocation					1,801	8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					18,654	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				\$	\$		85,875	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 78,910	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				\$	\$		\$ 78,910	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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

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**		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	Cole Taylor Bank		X	Mortgage	\$22,010.00	09/01/95	\$ 2,620,000	\$ 1,641,327		\$ 102,942	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Diawa Loan		X	Line of Credit				171,791		4,927	6									
7	Fairfax HC Properties	X						260,000		26,362	7									
8	See Supplemental Schedule										8									
9	TOTAL Facility Related				\$22,010.00		\$ 2,620,000	\$ 2,073,118		\$ 134,231	9									
B. Non-Facility Related*																				
10	Interest Income		X							(14,582)	10									
11	Allocated from CCI		X							16,029	11									
12	Allocated from Clinical		X							1,536	12									
13	See Supplemental Schedule									1,262	13									
14	TOTAL Non-Facility Related						\$	\$		\$ 4,245	14									
15	TOTALS (line 9+line14)						\$ 2,620,000	\$ 2,073,118		\$ 138,476	15									

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

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

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15	Allocated from Health Sys.		X				\$	\$			\$	595	15
16	Allocated from Ventlease		X									667	16
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											1,262	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.)

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr# 0041186 Report Period Beginning: 01/01/07Ending: 12/31/07

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2006 report.			\$	180,500	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.)			\$	176,354	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(4,146)	3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	183,708	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	179,562	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	2002	<u>129,274</u>	<u>8</u>			
	2003	<u>152,523</u>	<u>9</u>			
	2004	<u>164,540</u>	<u>10</u>			
	2005	<u>171,934</u>	<u>11</u>			
	2006	<u>174,960</u>	<u>12</u>			
<u>2007 Accrual = \$174,960 x 1.05</u>						
<u>Care Centers Allocation \$1,394</u>						
<u>The real estate tax bill in the amount of \$2,750.39 is related to the assisted living parcel. This amount has been adjusted out on Page 5A.</u>						
				FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$				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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 Nursing & Rehab Ctr

0041186 Report Period Beginning:

01/01/07 Ending:

12/31/07

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living Facility

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

1. Total Amount Incurred: _____ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>84,986</u>	1
2	<u>Allocated from Care Centers</u>			<u>7,272</u>	2
3	TOTALS			\$ 92,258	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1995		24,431		20	1,222	1,222	14,988	9
10	Various		1996		82,791		20	4,140	4,140	48,555	10
11	Various		1997		44,854		20	2,245	2,245	23,587	11
12	Various		1998		47,497		20	2,478	2,478	24,435	12
13	Various		1999		39,389		20	1,972	1,972	17,180	13
14	Various		2000		13,995		20	701	701	5,218	14
15	Various		2001		20,621		20	1,033	1,033	6,895	15
16	Various		2002		8,353		20	715	715	4,494	16
17	Various		2003		20,578		20	1,557	1,557	7,142	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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		2,932,035	76,346		146,602	70,256	1,808,090	67
68		40,102	2,135		2,135		13,225	68
69			71,053			(71,053)		69
70		\$ 3,274,646	\$ 149,534		\$ 164,800	\$ 15,266	\$ 1,973,809	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

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12/31/07

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,274,646	\$ 149,534		\$ 164,800	\$ 15,266	\$ 1,973,809	1
2	Seco Refrigeration-Boiler Repairs	2004	802		20	160	160	641	2
3	Weather Temp	2004	939		20	94	94	375	3
4	Roof Repairs	2004	2,200		20	220	220	880	4
5	Screens	2004	800		20	80	80	320	5
6	Sprinkler	2004	1,512		20	151	151	605	6
7	Eltek Corp-Hvac	2004	1,265		20	253	253	1,012	7
8	Heating Coil	2004	2,055		20	206	206	788	8
9	Electrical Repairs	2004	766		20	77	77	287	9
10	Cement Work	2004	2,887		20	289	289	986	10
11	Eltek Corp-Ac Condensing Unit	2004	3,224		20	645	645	2,203	11
12	Generator	2004	601		20	120	120	411	12
13	Parking Signs	2004	555		20	56	56	180	13
14	Interior Remodel	2004	17,647		20	1,765	1,765	5,735	14
15	New Driveway	2004	4,960		20	496	496	1,612	15
16	Hvac Repair	2004	1,484		20	148	148	458	16
17	Roofing	2004	1,100		20	110	110	339	17
18	Warewasher Motor, Impeller	2004	1,289		20	129	129	397	18
19	Construction	2004	14,318		20	1,432	1,432	4,415	19
20	Cubicle Curtain	2004	1,288		20	258	258	837	20
21	Hvac - Saddle Valve	2004	628		20	31	31	97	21
22	Hvac - Motor, Fan Blade	2004	588		20	29	29	100	22
23	Repair Hot Water Line	2004	530		20	27	27	104	23
24	Conf Room/Ceiling	2005	31,000		20	3,100	3,100	7,492	24
25	Conf Room/Ceiling	2005	60,000		20	6,000	6,000	14,000	25
26	Utility Room	2005	7,899		20	790	790	1,646	26
27	A/C Repair	2005	1,647		20	82	82	213	27
28	Cold Patch	2005	5,683		20	568	568	1,184	28
29	Water Main	2005	30,670		20	3,067	3,067	6,390	29
30	Wage Damage	2005	3,956		20	363	363	726	30
31	Undercoater And Paint	2006	1,187		20	119	119	218	31
32	Painting Project	2006	1,935		20	194	194	355	32
33	Ice Cream Dipping Cabinet	2006	1,769		20	177	177	310	33
34	TOTAL (lines 1 thru 33)		\$ 3,481,830	\$ 149,534		\$ 186,036	\$ 36,502	\$ 2,029,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,481,830	\$ 149,534		\$ 186,036	\$ 36,502	\$ 2,029,125	1
2	Painting Project	2006	6,979		20	698	698	1,221	2
3	Sprinkler System Repair	2006	1,079		20	108	108	189	3
4	Painting Project	2006	116		20	12	12	20	4
5	Duct Detectors	2006	649		20	65	65	108	5
6	Paint	2006	411		20	41	41	69	6
7	Paint	2006	124		20	12	12	21	7
8	Painting Project	2006	2,154		20	215	215	359	8
9	June Ho Payroll	2006	2,836		20	284	284	449	9
10	Roof Repair	2006	1,500		20	150	150	300	10
11	Bldg Improvements - Paint	2006	755		20	63	63	126	11
12	Suburban Cost	2006	1,850		20	123	123	135	12
13	Boiler Repairs	2006	1,840		20	80	80		13
14	Replacement Of Heat Exchanger	2006	2,170		20	99	99		14
15	Painting / Decorating	2006	1,941		20	97	97		15
16	New Phone System	2007	9,291		20	542	542	542	16
17	Painting	2007	7,953		20	4,639	4,639	4,639	17
18	Painting	2007	1,193		20	696	696	696	18
19	Carpeting	2007	2,855		20	238	238	238	19
20	New Ceilings & Drywall	2007	10,400		20	1,213	1,213	1,213	20
21	Hvac Service	2007	4,584		20	535	535	535	21
22	Painting (Transfer Expense From Home Office)	2007	10,101		20	337	337	337	22
23	Painting (Transfer Expense From Home Office)	2007	14,393		20	360	360	360	23
24	New Air Compressor	2007	4,095		20	102	102	102	24
25	New Condensing Unit	2007	2,866		20	72	72	72	25
26	Painting (Transfer Expense From Home Office)	2007	14,349		20	239	239	239	26
27	Painting (Transfer Expense From Home Office)	2007	14,068		20	1,172	1,172	1,172	27
28	White Vinyl Wall Panels	2007	6,191		20	516	516	516	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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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16									16
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19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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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18									18
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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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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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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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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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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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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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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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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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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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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)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,608,573	\$ 149,534		\$ 198,744	\$ 49,210	\$ 2,042,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	\$ 76,346	20	\$ 146,602	\$ 70,256	\$ 1,808,090	4
5											5
6											6
7											7
8											8
Improvement Type**											
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											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	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								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	2,932,035	\$	76,346	\$	146,602	\$	70,256	\$	1,808,090	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocate Care Centers, Inc. 2201 Main LLC		2002	2002	\$ 7,599	\$ 195	39	\$ 195		\$ 1,031	4
5	Allocate Care Centers, Inc. - CCI Building			1996	12,885	330	39	330		3,648	5
6	Allocate Care Centers Clinical, Inc.		2002	2002	787	20	39	20		107	6
7	Allocate Care Centers Health Systems, Inc.		2002	2002	633	16	39	16		86	7
8											8
	Improvement Type**										
9	Allocate Care Centers, Inc. 2201 Main LLC			2002	6,277	574	20	574		2,874	9
10	Allocate Care Centers, Inc. 2201 Main LLC			2003	7,397	676	20	676		3,387	10
11	Allocate Care Centers, Inc. 2201 Main LLC			2005	368	39	20	39		93	11
12											12
13	Allocate Care Centers, Inc.			2007	78	5	20	5		5	13
14											14
15	Allocate Care Centers, Inc. - CCI Building			1996	217	-	20	-		217	15
16	Allocate Care Centers, Inc. - CCI Building			1997	1,237	40	20	40		589	16
17											17
18	Allocate Care Centers Clinical, Inc.			2002	650	59	20	59		298	18
19	Allocate Care Centers Clinical, Inc.			2003	766	70	20	70		351	19
20	Allocate Care Centers Clinical, Inc.			2005	38	4	20	4		10	20
21											21
22	Allocate Care Centers Health Systems, Inc.			2002	523	48	20	48		239	22
23	Allocate Care Centers Health Systems, Inc.			2003	616	56	20	56		282	23
24	Allocate Care Centers Health Systems, Inc.			2005	31	3	20	3		8	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	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								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	40,102	\$	2,135	\$	2,135	\$	13,225	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 443,812	\$ 8,738	\$ 27,080	\$ 18,342	10	\$ 380,633	71
72	Current Year Purchases	7,655	95	3,892	3,797	10	3,892	72
73	Fully Depreciated Assets	53,889				10	53,889	73
74								74
75	TOTALS	\$ 505,356	\$ 8,833	\$ 30,972	\$ 22,139		\$ 438,414	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	1997	\$ 47,208	\$	\$	\$	5	\$ 35,408	76
77		Allocate Care Centers, Inc.	2007	14,335	832	832		5	11,776	77
78		Allocate CC Clinical, Inc.	2007	1,395	181	181		5	264	78
79		Allocate CC Health Sys, Inc.	2007	338	11	11		5	11	79
80	TOTALS			\$ 63,276	\$ 1,024	\$ 1,024	\$		\$ 47,459	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)		\$ 4,269,463	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 159,391	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 230,740	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 71,349	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,528,656	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	<u>Allocated from Care Centers, Inc.</u>				<u>1,343</u>			5
6	<u>Allocated from Care Centers Health Systems</u>				<u>468</u>			6
7	TOTAL				\$ 1,811			7

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.	<u> </u> /2008	\$ <u> </u>
13.	<u> </u> /2009	\$ <u> </u>
14.	<u> </u> /2010	\$ <u> </u>

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: *

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: \$ 3,671 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 101,272	\$		\$ 101,272	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,314			7,314	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			90,353			90,353	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 prescripts				131,179		131,179	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						102,304		102,304	13
14	TOTAL			\$		\$ 198,939	\$ 233,483		\$ 432,422	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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (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	\$ (132,648)	\$ (55,133)	1
2	Cash-Patient Deposits	34,625	34,625	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	463,205	646,913	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115,091	115,091	6
7	Other Prepaid Expenses	360	360	7
8	Accounts Receivable (owners or related parties)		193,301	8
9	Other(specify): <u>See Attached Schedule</u>	1,546,877	1,546,877	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,027,510	\$ 2,482,034	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	545,357	545,357	15
16	Equipment, at Historical Cost	359,180	529,153	16
17	Accumulated Depreciation (book methods)	(613,563)	(1,717,583)	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): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 290,974	\$ 2,449,467	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,318,484	\$ 4,931,501	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,362,618	\$ 1,546,325	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,328	23,328	28
29	Short-Term Notes Payable	171,791	171,791	29
30	Accrued Salaries Payable	81,611	81,611	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,956	3,956	31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,708	183,708	32
33	Accrued Interest Payable		211,756	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	255,211		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,082,223	\$ 2,222,475	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		260,000	39
40	Mortgage Payable		1,641,327	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,901,327	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,082,223	\$ 4,123,802	46
47	TOTAL EQUITY(page 18, line 24)	\$ 236,261	\$ 807,699	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,318,484	\$ 4,931,501	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 780,949	1
2	Restatements (describe):		2
3	<u>Depreciation</u>	(6,371)	3
4	<u>Health Insurance Premiums</u>	(5,950)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 768,628	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(532,367)	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)	\$ (532,367)	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)	\$ 236,261	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr# 0041186Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,234,099	1
2	Discounts and Allowances for all Levels	(946,490)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,287,609	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	846,836	6
7	Oxygen	6,187	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 853,023	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	9	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	132,712	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,115	19
20	Radiology and X-Ray	7,890	20
21	Other Medical Services	57,946	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 220,672	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,582	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,582	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	10,278	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,278	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,386,164	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	875,755	31
32	Health Care	1,850,727	32
33	General Administration	1,118,852	33
B. Capital Expense			
34	Ownership	594,785	34
C. Ancillary Expense			
35	Special Cost Centers	432,422	35
36	Provider Participation Fee	45,990	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,918,531	40
41	Income before Income Taxes (line 30 minus line 40)**	(532,367)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (532,367)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning: 01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,946	2,136	\$ 72,428	\$ 33.91	1
2	Assistant Director of Nursing	67	106	3,422	32.28	2
3	Registered Nurses	7,718	8,628	212,906	24.68	3
4	Licensed Practical Nurses	24,581	27,092	617,475	22.79	4
5	CNAs & Orderlies	45,045	50,086	504,532	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,295	9,459	144,532	15.28	8
9	Activity Director	1,587	1,845	26,038	14.11	9
10	Activity Assistants	6,195	6,822	59,233	8.68	10
11	Social Service Workers	5,216	5,964	93,413	15.66	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,208	36,984	16.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,379	5,989	61,455	10.26	15
16	Dishwashers	9,313	10,524	102,326	9.72	16
17	Maintenance Workers	3,451	3,942	57,911	14.69	17
18	Housekeepers	9,862	11,267	111,593	9.90	18
19	Laundry	6,652	7,678	91,438	11.91	19
20	Administrator	1,946	2,306	69,739	30.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,703	6,261	69,120	11.04	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	1,941	2,193	27,634	12.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	146,859	164,506	\$ 2,362,179 *	\$ 14.36	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	201	\$ 8,641	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	3	190	10-03	38
39	Pharmacist Consultant	Monthly	1,150	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	32	1,575	11-03	44
45	Social Service Consultant	16	859	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	119	4,764	10a-03	47
48	<u>See Attached - Care Centers Alloc.</u>	38	1,694	10-03	48
49	TOTAL (lines 35 - 48)	409	\$ 27,873		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	24	796	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	\$ 796		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

0041186

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Crystal Wray	Administrator	0	\$ 65,150	Workers' Compensation Insurance	\$ 66,839	IDPH License Fee	\$ 1,161		
Diane E. Walker	Administrator	0	4,589	Unemployment Compensation Insurance	35,882	Advertising: Employee Recruitment	7,617		
				FICA Taxes	176,827	Health Care Worker Background Check			
				Employee Health Insurance	81,451	(Indicate # of checks performed <u>180</u>)	5,748		
				Employee Meals		Patient Background Checks	90		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,069		
				Pension Expense	13,648	Licenses & Fees	1,600		
				Other Employee Welfare	1,835	Advertising & Promotions	11,936		
				Holiday Expense	2,565	See Supplemental Schedule	3,173		
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()		
(List each licensed administrator separately.)			\$ 69,739			Non-allowable advertising	(11,936)		
						Yellow page advertising	()		
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,458		
Description			Amount						
Care Centers Clinical - Management Fees			\$ 24,154						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 24,154						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 9,000				Out-of-State Travel	\$	
See Attached	Legal Fees		5,980						
ADP	Payroll Processing		7,199						
National Data Corp	Data Processing		1,382				In-State Travel		
eHealth Data Solutions	Data Processing		3,180						
Personnel Planners	Unemployment Consult.		2,826						
Care Centers, Inc.	Other Professional Fees		2,825						
Prospect Resources	Natural Gas Procurement		1,090				Seminar Expense	34	
Allegiance	Employee Compliance		205				Allocated from Care Centers, Inc.	508	
Chad Courneya	Medicare Consultant		119				Allocated from Care Center Clinical	270	
Care Centers, Inc.	Home Office Expense		165,275						
TOTAL (agree to Schedule V, line 19, column 3)							Entertainment Expense	()	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 199,081				(agree to Sch. V, line 24, col. 8)		
				TOTAL		\$	TOTAL	\$ 812	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$4,234, IL Assoc. HCF \$1,512
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,746 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 45,990
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No 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? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT