

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

0041186 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>20,496</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>28</u>	Intermediate (ICF)	<u>28</u>	<u>10,248</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>30,744</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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,225</u>	<u>1,498</u>	<u>5,693</u>	<u>28,416</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>21,225</u>	<u>1,498</u>	<u>5,693</u>	<u>28,416</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.43%

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

17 (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 5,303

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	199,637	27,562	9,563	236,762		236,762	(613)	236,149		1
2	Food Purchase		147,468		147,468		147,468	163	147,631		2
3	Housekeeping	116,067	23,964		140,031		140,031	(1,575)	138,456		3
4	Laundry	84,182	16,227		100,409		100,409	(116)	100,293		4
5	Heat and Other Utilities			133,280	133,280		133,280	1,765	135,045		5
6	Maintenance	67,553		150,363	217,916		217,916	29,728	247,644		6
7	Other (specify):*							4,971	4,971		7
8	TOTAL General Services	467,439	215,221	293,206	975,866		975,866	34,323	1,010,189		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,475,181	90,519	13,903	1,579,603		1,579,603	9,584	1,589,187		10
10a	Therapy	128,589			128,589		128,589	1,287	129,876		10a
11	Activities	83,708	7,552		91,260		91,260		91,260		11
12	Social Services	85,514	255	1,574	87,343		87,343	7,834	95,177		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,715	4,715		15
16	TOTAL Health Care and Programs	1,772,992	98,326	24,477	1,895,795		1,895,795	23,420	1,919,215		16
	C. General Administration										
17	Administrative	83,564			83,564		83,564	31,071	114,635		17
18	Directors Fees										18
19	Professional Services			232,748	232,748		232,748	(188,451)	44,297		19
20	Dues, Fees, Subscriptions & Promotions			40,350	40,350		40,350	(11,436)	28,914		20
21	Clerical & General Office Expenses	88,524	16,341	268,653	373,518		373,518	(121,199)	252,319		21
22	Employee Benefits & Payroll Taxes			458,123	458,123		458,123	(9,772)	448,351		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,238	6,238		6,238	571	6,809		24
25	Other Admin. Staff Transportation			8,348	8,348		8,348	948	9,296		25
26	Insurance-Prop.Liab.Malpractice			82,157	82,157		82,157	846	83,003		26
27	Other (specify):*							17,953	17,953		27
28	TOTAL General Administration	172,088	16,341	1,096,617	1,285,046		1,285,046	(279,469)	1,005,577		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,412,519	329,888	1,414,300	4,156,707		4,156,707	(221,726)	3,934,981		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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			132,318	132,318	132,318	138,272	270,590				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,175	24,175	24,175	133,784	157,959				32
33	Real Estate Taxes			195,094	195,094	195,094	(534)	194,560				33
34	Rent-Facility & Grounds			338,786	338,786	338,786	(334,672)	4,114				34
35	Rent-Equipment & Vehicles			3,263	3,263	3,263	656	3,919				35
36	Other (specify):*											36
37	TOTAL Ownership			693,636	693,636	693,636	(62,494)	631,142				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		357,932	398,715	756,647	756,647	(30,264)	726,383				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,116	46,116	46,116		46,116				42
43	Other (specify):*			648	648	648	(648)					43
44	TOTAL Special Cost Centers		357,932	445,479	803,411	803,411	(30,912)	772,499				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,412,519	687,820	2,553,415	5,653,754	5,653,754	(315,132)	5,338,622				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: 01/01/08

Ending: 12/31/08

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	44,785	30		9
10	Interest and Other Investment Income	(13,360)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	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	(13,845)	21		18
19	Entertainment				19
20	Contributions	(752)	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	(133,304)	21		24
25	Fund Raising, Advertising and Promotional	(10,746)	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	(74,883)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (202,182)		\$	30

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)	(112,951)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (112,951)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (315,132)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Tri-State Nursing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Theft Loss	\$ (222)	21	1
2	Collections	(525)	21	2
3	Other Income	(223)	21	3
4	Cable TV	(2,602)	06	4
5	Annual Report	(250)	20	5
6	COPE Dues	(3,002)	20	6
7	Trust Fees- Building Co.	(150)	20	7
8	Replacement Tax	(646)	21	8
9	Marketing Salaries	(648)	43	9
10	Prior Period- Office Expense	(12,019)	21	10
11	Non-Allowable Seminar	(330)	24	11
12	Assisted Living Parcel- Real Estate Taxes	(2,864)	33	12
13	Non-Allowable expense	(48,000)	21	13
14	Non-Allowable Legal Fees	(3,402)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(74,883)		49

Tri-State Nursing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

STATE OF ILLINOIS

Summary A

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

0041186

Report Period Beginning:

01/01/08

Ending:

12/31/08

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			240		1,762	(2,615)						(613)	1
2	Food Purchase	(77)		240									163	2
3	Housekeeping			239		26		(1,840)					(1,575)	3
4	Laundry							(116)					(116)	4
5	Heat and Other Utilities			1,444		60	261						1,765	5
6	Maintenance	(2,602)		1,823	28,713	7	44			1,743			29,728	6
7	Other (specify):*				4,743	228							4,971	7
8	TOTAL General Services	(2,679)		3,986	33,456	2,083	(2,310)	(1,957)		1,743			34,323	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					14,781		(5,197)					9,584	10
10a	Therapy					1,287							1,287	10a
11	Activities													11
12	Social Services					7,834							7,834	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,715							4,715	15
16	TOTAL Health Care and Programs					28,617		(5,197)					23,420	16
	C. General Administration													
17	Administrative			1,147	4,284	21,907	3,733						31,071	17
18	Directors Fees													18
19	Professional Services	(3,402)		(139,493)		(45,699)	143						(188,451)	19
20	Fees, Subscriptions & Promotions	(14,900)	150	3,183		4	127						(11,436)	20
21	Clerical & General Office Expenses	(208,784)	646	13,903	66,610	7,443	4,426			(5,443)			(121,199)	21
22	Employee Benefits & Payroll Taxes				(8,145)	(1,627)							(9,772)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(330)		809		92							571	24
25	Other Admin. Staff Transportation			693			245			10			948	25
26	Insurance-Prop.Liab.Malpractice			499		8	303			36			846	26
27	Other (specify):*				13,148	3,774	1,031						17,953	27
28	TOTAL General Administration	(227,416)	796	(119,259)	75,897	(14,098)	10,008			(5,397)			(279,469)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(230,095)	796	(115,273)	109,353	16,602	7,698	(7,154)		(3,654)			(221,726)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri-State Nursing & Rehab Ctr# 0041186

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	44,785	76,346	6,784		437	277			9,643			138,272	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,360)	123,060	18,026		3,336	850			1,872			133,784	32
33	Real Estate Taxes	(2,864)		2,233		97							(534)	33
34	Rent-Facility & Grounds		(337,260)	1,694			894						(334,672)	34
35	Rent-Equipment & Vehicles			570			86						656	35
36	Other (specify):*													36
37	TOTAL Ownership	28,561	(137,854)	29,307		3,870	2,107			11,515			(62,494)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(11,160)	(4,424)		(14,680)			(30,264)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(648)											(648)	43
44	TOTAL Special Cost Centers	(648)					(11,160)	(4,424)		(14,680)			(30,912)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(202,182)	(137,058)	(85,966)	109,353	20,472	(1,355)	(11,578)		(6,819)			(315,132)	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	195,094	Lansing Healthcare Properties	100.00%	195,094		2
3	V	20 Trust Fees		Lansing Healthcare Properties	100.00%	150	150	3
4	V	21 Replacement Tax		Lansing Healthcare Properties	100.00%	646	646	4
5	V	30 Depreciation		Lansing Healthcare Properties	100.00%	76,346	76,346	5
6	V	32 Interest		Lansing Healthcare Properties	100.00%	123,060	123,060	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 532,354			\$ 395,296	\$ * (137,058)	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: 01/01/08 Ending: 12/31/08

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. / Extended Care Consulting, LLC	100.00%	\$ 240	\$ 240	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	240	240	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	239	239	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,444	1,444	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,823	1,823	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,147	1,147	20	
21	V	19	Professional Fees	148,062	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,569	(139,493)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,183	3,183	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	13,903	13,903	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	809	809	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	693	693	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	499	499	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,784	6,784	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	18,026	18,026	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,233	2,233	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,694	1,694	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	570	570	31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 148,062			\$ 62,096	\$ * (85,966)	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	06 Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,520	\$ 3,520	15
16	V	06 Maintenance (Direct)	5,983	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	31,176	25,193	16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,097	1,097	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,646	3,646	18
19	V	17 Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,284	4,284	19
20	V	21 Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	66,610	66,610	20
21	V	21 Office and Clerical (Direct)	24,164	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	24,164		21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	10,579	10,579	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,569	2,569	23
24	V							24
25	V	22 Employee Benefits	8,145	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%		(8,145)	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		\$ 38,292			\$ 147,645	\$ * 109,353	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: 01/01/08 Ending: 12/31/08

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. / Extended Care Clinical, LLC	100.00%	\$ 26	\$ 26	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	60	60	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7	7	17	
18	V	19	Professional Fees	46,370	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	671	(45,699)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	4	4	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	114	114	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	92	92	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	8	8	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	437	437	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,336	3,336	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	97	97	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,762	1,762	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	228	228	27	
28	V	10	Nursing Salary	11,890	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	26,671	14,781	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,287	1,287	29	
30	V	12	Social Service Salary	1,574	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9,408	7,834	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	4,715	4,715	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	21,907	21,907	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7,329	7,329	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,774	3,774	34	
35	V								35	
36	V	22	Emp. Ben. - Healthcare	1,627	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%		(1,627)	36	
37	V								37	
38	V								38	
39	Total			\$ 61,461			\$ 81,933	\$ * 20,472	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: 01/01/08 Ending: 12/31/08

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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 2,310	\$ 2,310	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	261	261	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	44	44	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	143	143	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	127	127	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	567	567	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	245	245	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	303	303	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	277	277	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	850	850	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	894	894	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	86	86	28
29	V	01 Dietary	7,803	Care Centers Health Systems, Inc.	100.00%	2,878	(4,925)	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		Care Centers Health Systems, Inc.	100.00%			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	17,681	Care Centers Health Systems, Inc.	100.00%	6,521	(11,160)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	3,733	3,733	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	3,859	3,859	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,031	1,031	38
39	Total		\$ 25,484			\$ 24,129	\$ * (1,355)	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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	20,776	Xcel Supply, LLC	100.00%	18,936	(1,840)	16
17	V	4 Laundry	1,313	Xcel Supply, LLC	100.00%	1,197	(116)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	58,673	Xcel Supply, LLC	100.00%	53,476	(5,197)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			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	49,945	Xcel Supply, LLC	100.00%	45,521	(4,424)	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		\$ 130,707			\$ 119,129	\$ * (11,578)	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 95,657	\$ 95,657	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	95,657	CCS Employee Benefits Group	100.00%		(95,657)	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			\$ 95,657			\$ 95,657	\$ *	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	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 1,743	\$ 1,743	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	196	196	16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%	10	10	17
18	V	26	Insurance		Vent Lease, LLC.	100.00%	36	36	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	5,796	5,796	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	978	978	20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	3,847	3,847	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	894	894	22
23	V	21	Office and Clerical	5,639	Vent Lease, LLC.	100.00%		(5,639)	23
24	V	39	Ancillary	14,680	Vent Lease, LLC.	100.00%		(14,680)	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		\$ 20,319				\$ 13,500	\$ * (6,819)	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.

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.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	0.58	1.26%		\$	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	0.96	1.75%	Alloc. Salary	2,657	17-7	2
3	Adam Vales	Owner	Clerical	4.76%	See Attached	0.73	1.83%	Alloc. Salary	1,317	22-7	3
4	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.30	1.80%	Alloc. Salary	267	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,241		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: 01/01/08

Ending: 12/31/08

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	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: 01/01/08

Ending: 12/31/08

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

1	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	01	Dietary	Patient Days	1,635,146	31	\$ 13,778	\$ 28,416	\$ 240	1
2	02	Food	Patient Days	1,635,146	31	13,971	28,416	240	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	28,416	239	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	28,416	1,444	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	28,416	1,823	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	28,416	1,147	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	28,416	8,569	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	28,416	3,183	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	28,416	13,903	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	28,416	809	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	28,416	693	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	28,416	499	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	28,416	6,784	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	28,416	18,026	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	28,416	2,233	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	28,416	1,694	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	28,416	570	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 62,096	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

1	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	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	28,416	3,520	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		31,176	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		28,416	1,097	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			3,646	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	28,416	4,284	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	28,416	66,610	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		24,164	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		28,416	10,579	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			2,569	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					\$ 6,211,280	\$ 5,395,924		\$ 147,645	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning: 01/01/08

Ending: 12/31/08

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/Extended Care Clinical
 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	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 28,416	\$ 26	1	
2	05	Utilities	Patient Days	1,635,146	31	3,449	28,416	60	2	
3	06	Maintenance	Patient Days	1,635,146	31	431	28,416	7	3	
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	28,416	671	4	
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	28,416	4	5	
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	28,416	114	6	
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	28,416	92	7	
8	26	Insurance	Patient Days	1,635,146	31	465	28,416	8	8	
9	30	Depreciation	Patient Days	1,635,146	31	25,565	28,416	437	9	
10	32	Interest	Patient Days	1,635,146	31	191,164	28,416	3,336	10	
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	28,416	97	11	
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	28,416	1,762	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	28,416	228	13	
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	28,416	15,104	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	28,416	1,287	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	28,416	7,511	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	28,416	3,088	17	
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	28,416	21,907	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	28,416	7,329	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	28,416	3,774	20	
21	10	Nursing Salary	Direct Allocation			401,447	401,447		11,567	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016		1,897	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816			1,627	23
24										24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 81,933		25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

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	01	Dietary	Gross Billable Income	31	111,096		80,423	2,310	1
2	03	Housekeeping	Gross Billable Income	31			80,423		2
3	05	Heat and Other Utilities	Gross Billable Income	31	12,529		80,423	261	3
4	06	Maintenance	Gross Billable Income	31	2,136		80,423	44	4
5	19	Professional Fees	Gross Billable Income	31	6,873		80,423	143	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	6,095		80,423	127	6
7	21	Clerical and General Office	Gross Billable Income	31	27,280		80,423	567	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	11,773		80,423	245	8
9	26	Insurance	Gross Billable Income	31	14,568		80,423	303	9
10	30	Depreciation	Gross Billable Income	31	13,298		80,423	277	10
11	32	Interest	Gross Billable Income	31	40,850		80,423	850	11
12	33	Real Estate Taxes	Gross Billable Income	31			80,423		12
13	34	Rent - Building	Gross Billable Income	31	43,000		80,423	894	13
14	35	Rent - Equipment	Gross Billable Income	31	4,135		80,423	86	14
15	01	Dietary	Direct Billable Income	31	102,965		7,803	2,878	15
16	02	Food	Direct Billable Income	31	1,612				16
17	03	Housekeeping	Direct Billable Income	31					17
18	10	Nursing	Direct Billable Income	31					18
19	21	Clerical and General Office	Direct Billable Income	31					19
20	25	Other Admin. Staff Transport.	Direct Billable Income	31					20
21	39	Ancillary	Direct Billable Income	31	1,321,550		17,681	6,521	21
22	17	Administrative	Gross Billable Income	31	179,474	179,474	80,423	3,733	22
23	21	Clerical and General Office	Gross Billable Income	31	185,549	185,549	80,423	3,859	23
24	27	Employee Benefits	Gross Billable Income	31	49,573		80,423	1,031	24
25	TOTALS				\$ 2,134,357	\$ 365,023		\$ 24,129	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning: 01/01/08

Ending: 12/31/08

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							1
2	3	Housekeeping						18,936	2
3	4	Laundry						1,197	3
4	6	Repairs & Maintenance							4
5	10	Nursing						53,476	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions							8
9	21	Office And Clerical							9
10	22	Employee Benefits							10
11	24	Seminars & Education							11
12	39	Ancillary						45,521	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							119,129	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/08

Ending: 12/31/08

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		\$	\$		\$ 95,657	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				\$	\$		\$ 95,657	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	06	Repairs	669,310	26	\$ 79,460	\$	14,680	\$ 1,743	1
2	21	Office and Clerical	669,310	26	8,933		14,680	196	2
3	25	Auto Expense / Travel	669,310	26	473		14,680	10	3
4	26	Insurance	669,310	26	1,630		14,680	36	4
5	30	Depreciation	669,310	26	264,263		14,680	5,796	5
6	32	Interest	669,310	26	44,568		14,680	978	6
7	30	Depreciation - Matrix	1,635,146	31	221,356		28,416	3,847	7
8	32	Interest - Matrix	1,635,146	31	51,456		28,416	894	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				\$ 672,138	\$		\$ 13,500	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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	\$ 1,514,816		\$ 96,626	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Diawa Loan		X	Line of Credit				494,413		24,175	6									
7	Fairfax HC Properties	X						260,000		26,433	7									
8	See Supplemental Schedule									24,084	8									
9	TOTAL Facility Related				\$22,010.00		\$ 2,620,000	\$ 2,269,229		\$ 171,318	9									
B. Non-Facility Related*																				
10	Interest Income		X							(13,360)	10									
11											11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		(13,360)	14									
15	TOTALS (line 9+line14)						\$ 2,620,000	\$ 2,269,229		\$ 157,958	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: 01/01/08 Ending: 12/31/08

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

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Alloc.- CCC/ECC		X				\$	\$			\$	3,336	8						
9	Alloc.- CC Health Systems		X									850	9						
10	Alloc.- CCI/ECC		X									18,026	10						
11	Alloc.- Vent Lease		X									1,872	11						
12													12						
13													13						
14	TOTAL Working Capital											24,084	14						
	B. Non-Facility Related*																		
15							\$	\$			\$		15						
16													16						
17													17						
18													18						
19													19						
20	TOTAL Non-Facility Related												20						

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 183,708	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.)		\$ 184,247	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 539	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 194,021	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.		\$ 194,560	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<u>152,523</u>	<u>8</u>
	2004	<u>164,540</u>	<u>9</u>
	2005	<u>171,934</u>	<u>10</u>
	2006	<u>174,960</u>	<u>11</u>
	2007	<u>181,917</u>	<u>12</u>
2007 Accrual = \$184,781 x 1.05 = \$194,021			
Alloc. - CCI/ECC \$2,530			
Alloc. - CCC/ECC \$110			

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 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 Bureau of Health Finance at (217) 782-1630.

2007 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 2007 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 2007.

(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. <u>30-30-305-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>184,781.44</u>	\$ <u>181,917.00</u>
2. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>950.22</u>
3. <u>See Attached</u>	<u>Care Centerst Building Allocation</u>	\$ <u>43,667.89</u>	\$ <u>999.25</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>350,572.08</u>	\$ <u>183,866.47</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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:

01/01/08 Ending:

12/31/08

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 CCI/ECC</u>			<u>7,327</u>	2
3	TOTALS			\$ 92,313	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	16,209	9
10	Various		1996		82,791		20	4,140	4,140	52,693	10
11	Various		1997		44,854		20	2,245	2,245	25,832	11
12	Various		1998		47,497		20	2,375	2,375	26,809	12
13	Various		1999		39,389		20	1,972	1,972	19,151	13
14	Various		2000		13,995		20	701	701	5,918	14
15	Various		2001		20,621		20	1,033	1,033	7,924	15
16	Various		2002		8,353		20	643	643	5,135	16
17	Various		2003		20,578		20	1,557	1,557	8,699	17
18	Various		2004		61,438		20	6,776	6,776	29,558	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:

01/01/08

Ending:

12/31/08

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	1,954,692	67
68		40,923	2,159		2,159		14,107	68
69			132,317			(132,317)		69
70		\$ 3,336,905	\$ 210,822		\$ 171,425	\$ (39,397)	\$ 2,166,727	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:

01/01/08

Ending:

12/31/08

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		\$ 3,336,905	\$ 210,822		\$ 171,425	\$ (39,397)	\$ 2,166,727	1
2	Conf Room/Ceiling	2005	31,000		20	3,100	3,100	10,592	2
3	Conf Room/Ceiling	2005	60,000		20	6,000	6,000	20,000	3
4	Utility Room	2005	7,899		20	790	790	2,436	4
5	A/C Repair	2005	1,647		20	82	82	295	5
6	Cold Patch	2005	5,683		20	568	568	1,752	6
7	Water Main	2005	30,670		20	3,067	3,067	9,457	7
8	Wage Damage	2005	3,956		20	363	363	1,089	8
9	Painting Project	2006	1,935		20	194	194	548	9
10	Ice Cream Dipping Cabinet	2006	1,769		20	177	177	486	10
11	Painting Project	2006	6,979		20	698	698	1,919	11
12	Painting Project	2006	116		20	12	12	32	12
13	Duct Detectors	2006	649		20	65	65	173	13
14	Paint	2006	411		20	41	41	110	14
15	Paint	2006	124		20	12	12	33	15
16	Painting Project	2006	2,154		20	215	215	574	16
17	June Ho Payroll	2006	2,836		20	284	284	733	17
18	Roof Repair	2006	1,500		20	150	150	450	18
19	Paint	2006	755		20			755	19
20	Suburban Cost	2006	1,850		20	123	123	258	20
21	Boiler Repairs	2006	1,840		20	92	92	276	21
22	Replacement Of Heat Exchanger	2006	2,170		20	109	109	327	22
23	Painting / Decorating	2006	1,941		20	97	97	5,823	23
24	Undercoater And Paint	2006	1,187		20	119	119		24
25	Sprinkler System Repair	2006	1,079		20	108	108		25
26	New Phone System	2007	9,291		20	929	929	1,471	26
27	Painting (Transfer Expense From Home Office)	2007	9,146		20	3,811	3,811	9,146	27
28	Carpeting	2007	2,855		20	408	408	646	28
29	New Ceilings & Drywall	2007	10,400		20	2,080	2,080	3,293	29
30	Hvac Service	2007	4,584		20	917	917	1,452	30
31	Painting (Transfer Expense From Home Office)	2007	10,101		20	1,010	1,010	1,347	31
32	Painting (Transfer Expense From Home Office)	2007	14,393		20	1,439	1,439	1,799	32
33	New Air Compressor	2007	4,095		20	410	410	512	33
34	TOTAL (lines 1 thru 33)		\$ 3,571,920	\$ 210,822		\$ 198,895	\$ (11,927)	\$ 2,244,511	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:

01/01/08

Ending:

12/31/08

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		\$ 3,571,920	\$ 210,822		\$ 198,895	\$ (11,927)	\$ 2,244,511	1
2	New Condensing Unit	2007	2,866		20	287	287	358	2
3	Painting (Transfer Expense From Home Office)	2007	14,349		20	1,435	1,435	1,674	3
4	Painting (Transfer Expense From Home Office)	2007	14,068		20	12,896	12,896	14,068	4
5	White Vinyl Wall Panels	2007	6,191		20	5,675	5,675	6,191	5
6	Painting (Transfer From Home Office)	2008	5,208		20	5,208	5,208	5,208	6
7	Install Fire Alarms & New Smoke Detectors	2008	3,335		20	476	476	476	7
8	14 Coaxial Cable Runs	2008	2,602		20	239	239	239	8
9	Painting (Transfer From Home Office)	2008	5,424		20	4,520	4,520	4,520	9
10	Painting (Transfer From Home Office)	2008	10,282		20	7,712	7,712	7,712	10
11	Painting (Transfer From Home Office)	2008	5,909		20	3,939	3,939	3,939	11
12	Painting (Transfer From Home Office)	2008	5,302		20	3,093	3,093	3,093	12
13	2 New Laundry Rooms	2008	15,900		20	795	795	795	13
14	New Condensing Unit	2008	3,503		20	175	175	175	14
15	Telephone System Upgrade	2008	4,299		20	179	179	179	15
16	Remodel Entire Shower Room	2008	10,500		20	263	263	263	16
17	Heating Repairs	2008	2,644		20	44	44	44	17
18	Heating Repairs	2008	11,201		20	187	187	187	18
19	Heating Repairs	2008	7,149		20	60	60	60	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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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
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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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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
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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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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 12H, Carried Forward	\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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)	\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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)		\$ 3,702,652	\$ 210,822		\$ 246,078	\$ 35,256	\$ 2,293,692	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:

01/01/08

Ending:

12/31/08

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		195	1962	\$ 2,932,035	\$ 76,346	20	\$ 146,602	\$ 70,256	\$ 1,954,692	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:

01/01/08

Ending:

12/31/08

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	\$	1,954,692	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:

01/01/08

Ending:

12/31/08

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		Allocated from EC/CC Clinical, Inc.	2002	2002	\$ 858	\$ 22	39	\$ 22		\$ 138	4
5		Allocated from CCI/ECC - CCI Building		1996	13,562	348	39	348		4,187	5
6		Allocated from CCI/Extended Care Consulting, LLC	2002	2002	8,182	210	39	210		1,320	6
7											7
8											8
		Improvement Type**									
9		Allocated from CCI/Extended Care Consulting, LLC		2002	6,759	618	20	618		3,095	9
10		Allocated from CCI/Extended Care Consulting, LLC		2003	7,966	728	20	728		3,647	10
11		Allocated from CCI/Extended Care Consulting, LLC		2005	398	42	20	42		101	11
12		Allocated from CCI/Extended Care Consulting, LLC		2007	83	4	20	4		10	12
13											13
14		Allocated from CCI/ECC- CCI Building		1996	229	-	20	-		229	14
15		Allocated from CCI/ECC- CCI Building		1997	1,302	42	20	42		662	15
16											16
17		Allocated from CC/EC Clinical, Inc.		2002	708	65	20	65		325	17
18		Allocated from CC/EC Clinical, Inc.		2003	835	76	20	76		382	18
19		Allocated from CC/EC Clinical, Inc.		2005	41	4	20	4		11	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:

01/01/08

Ending:

12/31/08

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)	\$	40,923	\$	2,159	\$	2,159	\$	14,107	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: 01/01/08 Ending: 12/31/08

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	\$ 411,118	\$ 13,690	\$ 21,561	\$ 7,871	10	\$ 366,194	71
72	Current Year Purchases	13,873	28	1,686	1,658	10	1,686	72
73	Fully Depreciated Assets	96,523				10	96,523	73
74								74
75	TOTALS	\$ 521,514	\$ 13,718	\$ 23,247	\$ 9,529		\$ 464,403	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	1997	\$ 47,208	\$	\$	\$	5	\$ 35,408	76
77		Allocated from CCC/EC Clinical	2008	1,229	246	246		5	478	77
78		Allocated from CCI/ECC	2008	15,540	966	966		5	13,360	78
79		Allocated from CC Health Sys	2008	263	53	53		5	61	79
80	TOTALS			\$ 64,240	\$ 1,265	\$ 1,265	\$		\$ 49,307	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)	\$ 4,380,719	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 225,805	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 270,590	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,785	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,807,402	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	<u>Storage</u>			<u>1,526</u>			4
5	Alloc.- CCI/ECC				<u>1,694</u>			5
6	Alloc.- CC Health Systems				<u>894</u>			6
7	TOTAL				\$ <u>4,114</u>			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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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: \$ 3,918 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$		\$ 200,426	\$		\$ 200,426	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			18,632			18,632	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			166,247			166,247	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				209,042		209,042	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					13,410	148,890		162,300	13
14	TOTAL			\$		\$ 398,715	\$ 357,932		\$ 756,647	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: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	\$ 1,000	\$ 85,454	1
2	Cash-Patient Deposits	29,540	179,540	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,077,926	1,271,947	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,368	116,368	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		274,541	8
9	Other(specify): <u>See Attached Schedule</u>	1,418,777	1,698,988	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,643,611	\$ 3,626,838	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	681,339	681,339	15
16	Equipment, at Historical Cost	376,921	546,894	16
17	Accumulated Depreciation (book methods)	(756,888)	(1,937,254)	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)	\$ 301,372	\$ 2,383,519	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,944,983	\$ 6,010,357	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,808,269	\$ 2,002,291	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,219	25,219	28
29	Short-Term Notes Payable	494,413	494,413	29
30	Accrued Salaries Payable	96,741	96,741	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,896	5,896	31
32	Accrued Real Estate Taxes(Sch.IX-B)	194,021	194,021	32
33	Accrued Interest Payable		238,041	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	362,729	512,729	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,987,288	\$ 3,569,351	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		260,000	39
40	Mortgage Payable		1,514,816	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)	\$	\$ 1,774,816	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,987,288	\$ 5,344,167	46
47	TOTAL EQUITY(page 18, line 24)	\$ (42,305)	\$ 666,190	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,944,983	\$ 6,010,357	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 236,261	1
2	Restatements (describe):		2
3	Leasehold Improvement/ A/D Leasehold Improvement	36,017	3
4	Union Dues/ 401K	(1,381)	4
5	Rounding	(5)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 270,892	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(313,197)	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)	\$ (313,197)	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)	\$ (42,305)	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: 01/01/08Ending: 12/31/08**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	\$ 5,266,262	1
2	Discounts and Allowances for all Levels	(1,973,288)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,292,974	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,655,535	6
7	Oxygen	12,337	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,667,872	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	8	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	213,065	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,070	19
20	Radiology and X-Ray	6,610	20
21	Other Medical Services	119,375	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 366,128	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,360	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,360	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	223	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 223	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,340,557	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	975,866	31
32	Health Care	1,895,795	32
33	General Administration	1,285,046	33
B. Capital Expense			
34	Ownership	693,636	34
C. Ancillary Expense			
35	Special Cost Centers	757,295	35
36	Provider Participation Fee	46,116	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,653,754	40
41	Income before Income Taxes (line 30 minus line 40)**	(313,197)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (313,197)	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: 01/01/08

Ending:

12/31/08

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	1,831	2,053	\$ 80,024	\$ 38.98	1
2	Assistant Director of Nursing	450	588	19,756	33.60	2
3	Registered Nurses	8,928	9,936	261,846	26.35	3
4	Licensed Practical Nurses	22,866	25,500	587,633	23.04	4
5	CNAs & Orderlies	43,821	48,596	495,815	10.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,604	9,609	128,589	13.38	8
9	Activity Director	1,833	2,053	30,986	15.09	9
10	Activity Assistants	5,475	6,160	52,722	8.56	10
11	Social Service Workers	3,826	4,366	85,514	19.59	11
12	Dietician					12
13	Food Service Supervisor	1,909	2,178	40,628	18.65	13
14	Head Cook	4,114	4,825	51,782	10.73	14
15	Cook Helpers/Assistants	10,025	11,223	107,227	9.55	15
16	Dishwashers					16
17	Maintenance Workers	3,863	4,349	67,553	15.53	17
18	Housekeepers	9,872	11,217	116,067	10.35	18
19	Laundry	5,656	6,605	84,182	12.75	19
20	Administrator	1,635	1,949	72,917	37.41	20
21	Assistant Administrator	320	320	10,647	33.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,813	7,009	88,524	12.63	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	1,919	2,095	30,107	14.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	142,760	160,631	\$ 2,412,519 *	\$ 15.02	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	209	\$ 9,563	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	1,823	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>See Attached- Care Centers Alloc.</u>		11,890	10-03	47
48	<u>See Attached- Care Centers Alloc.</u>		1,574	12-03	48
49	TOTAL (lines 35 - 48)	212	\$ 34,040		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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14													
15													
16													
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. ICLTC \$5,830; IL Assoc of HCF \$1,008
- (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. \$ 18,657 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. \$ 46,116
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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT