

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

0041186 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF	<u>18,238</u>	<u>2,306</u>	<u>6,876</u>	<u>27,420</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>18,238</u>	<u>2,306</u>	<u>6,876</u>	<u>27,420</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.43%

D. How many bed-hold days during this year were paid by the Department? 13 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 9/1/1995

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/1/1995 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 6,290

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	208,032	35,484	14,078	257,594		257,594	(1,230)	256,364		1
2	Food Purchase		165,799		165,799		165,799	162	165,961		2
3	Housekeeping	135,637	24,372		160,009		160,009	(1,615)	158,394		3
4	Laundry	81,700	8,582		90,282		90,282	(349)	89,933		4
5	Heat and Other Utilities			96,904	96,904		96,904	1,355	98,259		5
6	Maintenance	52,388		96,655	149,043		149,043	(39,706)	109,337		6
7	Other (specify):*							1,985	1,985		7
8	TOTAL General Services	477,757	234,237	207,637	919,631		919,631	(39,398)	880,233		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,413,071	84,297	22,674	1,520,042		1,520,042	9,261	1,529,303		10
10a	Therapy	139,693			139,693		139,693	916	140,609		10a
11	Activities	86,555	6,596		93,151		93,151		93,151		11
12	Social Services	84,406	133	5,999	90,538		90,538	4,792	95,330		12
13	CNA Training										13
14	Program Transportation			815	815		815		815		14
15	Other (specify):*							6,752	6,752		15
16	TOTAL Health Care and Programs	1,723,725	91,026	38,488	1,853,239		1,853,239	21,721	1,874,960		16
	C. General Administration										
17	Administrative	95,289		4,200	99,489		99,489	30,664	130,153		17
18	Directors Fees										18
19	Professional Services			249,422	249,422	(4,000)	245,422	(196,627)	48,795		19
20	Dues, Fees, Subscriptions & Promotions			31,226	31,226		31,226	(11,148)	20,078		20
21	Clerical & General Office Expenses	60,432	17,266	137,617	215,315		215,315	11,882	227,197		21
22	Employee Benefits & Payroll Taxes			519,830	519,830		519,830	(12,400)	507,430		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,499	8,499		8,499	575	9,074		24
25	Other Admin. Staff Transportation			4,599	4,599		4,599	323	4,922		25
26	Insurance-Prop.Liab.Malpractice			93,137	93,137		93,137	881	94,018		26
27	Other (specify):*							21,865	21,865		27
28	TOTAL General Administration	155,721	17,266	1,048,530	1,221,517	(4,000)	1,217,517	(153,985)	1,063,532		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,357,203	342,529	1,294,655	3,994,387	(4,000)	3,990,387	(171,662)	3,818,725		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			61,440	61,440		61,440	166,283	227,723			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,684	49,684		49,684	141,683	191,367			32
33	Real Estate Taxes			302,034	302,034	4,000	306,034	1,231	307,265			33
34	Rent-Facility & Grounds			338,793	338,793		338,793	(334,096)	4,697			34
35	Rent-Equipment & Vehicles			2,902	2,902		2,902	1,373	4,275			35
36	Other (specify):*											36
37	TOTAL Ownership			754,853	754,853	4,000	758,853	(23,526)	735,327			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		354,649	608,758	963,407		963,407	(34,323)	929,084			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):*			540	540		540	(540)				43
44	TOTAL Special Cost Centers		354,649	655,288	1,009,937		1,009,937	(34,863)	975,074			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,357,203	697,178	2,704,796	5,759,177		5,759,177	(230,051)	5,529,126			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

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	75,888	30		9
10	Interest and Other Investment Income	(17,048)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(138)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(63)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,195)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,393)	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	(83,802)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,750)		\$	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)	(175,300)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (175,300)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (230,051)		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 Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medical Record Income	\$ (276)	10	1
2	Indiana Tax Refund	(1,341)	21	2
3	Account Collection Expense	(5,804)	21	3
4	Non-Allowable Repairs	(7,150)	06	4
5	Prior Period Dietary Consultant Cost	(878)	01	5
6	Prior Period Improvements	(3,735)	06	6
7	Non-Allowable Office Expense	(43,800)	21	7
8	Marketing Expense	(540)	43	8
9	Annual Report	(350)	20	9
10	COPE Dues	(2,593)	20	10
11	Non-Allowable Legal	(9,669)	19	11
12	Building Company Professional Fees	(5,750)	19	12
13	Building Company Replacement Taxes	(750)	21	13
14	Non-Care Depreciation	(1,166)	30	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	(83,802)		49

Tri-State Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(878)		135		2,341				(2,828)			(1,230)	1
2	Food Purchase	(138)		300									162	2
3	Housekeeping			280		31	(1,926)						(1,615)	3
4	Laundry						(349)						(349)	4
5	Heat and Other Utilities			1,149		74				132			1,355	5
6	Maintenance	(10,885)	(37,440)	1,783	4,367	10			2,358	101			(39,706)	6
7	Other (specify):*				1,645	340							1,985	7
8	TOTAL General Services	(11,901)	(37,440)	3,647	6,012	2,796	(2,275)		2,358	(2,595)			(39,398)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(339)				15,939	(6,335)			(4)			9,261	10
10a	Therapy					916							916	10a
11	Activities													11
12	Social Services					4,930	(138)						4,792	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,752							6,752	15
16	TOTAL Health Care and Programs	(339)				28,537	(6,473)			(4)			21,721	16
	C. General Administration													
17	Administrative			1,315	4,768	20,791				3,790			30,664	17
18	Directors Fees													18
19	Professional Services	(15,419)	5,750	(141,498)		(45,730)			129	141			(196,627)	19
20	Fees, Subscriptions & Promotions	(12,336)		1,126		4				58			(11,148)	20
21	Clerical & General Office Expenses	(71,890)	750	9,212	71,720	4,662			(7,158)	4,586			11,882	21
22	Employee Benefits & Payroll Taxes				(5,226)	(7,174)							(12,400)	22
23	Inservice Training & Education													23
24	Travel and Seminar			35		540							575	24
25	Other Admin. Staff Transportation			205					10	108			323	25
26	Insurance-Prop.Liab.Malpractice			452		27			133	269			881	26
27	Other (specify):*				16,599	3,612				1,654			21,865	27
28	TOTAL General Administration	(99,645)	6,500	(129,153)	87,861	(23,268)			(6,886)	10,606			(153,985)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(111,885)	(30,940)	(125,506)	93,873	8,065	(8,748)		(4,528)	8,007			(171,662)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	74,722	76,347	2,302		510			12,125	277			166,283	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,048)	116,611	33,845		6,160			2,115				141,683	32
33	Real Estate Taxes			1,110		121							1,231	33
34	Rent-Facility & Grounds		(337,260)	1,926						1,238			(334,096)	34
35	Rent-Equipment & Vehicles			1,360						13			1,373	35
36	Other (specify):*													36
37	TOTAL Ownership	57,674	(144,302)	40,543		6,791			14,240	1,528			(23,526)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,888)		(23,960)	(7,475)			(34,323)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(540)											(540)	43
44	TOTAL Special Cost Centers	(540)					(2,888)		(23,960)	(7,475)			(34,863)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(54,750)	(175,242)	(84,963)	93,873	14,856	(11,636)		(14,248)	2,060			(230,051)	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 Rental Income	\$ 337,260	Lansing Healthcare Properties	100.00%	\$	(337,260)	1
2	V	33 Real Estate Taxes	308,965	Lansing Healthcare Properties	100.00%	308,965		2
3	V	21 State Replacement Tax		Lansing Healthcare Properties	100.00%	750	750	3
4	V	19 Professional Fee		Lansing Healthcare Properties	100.00%	5,750	5,750	4
5	V	30 Depreciation		Lansing Healthcare Properties	100.00%	76,347	76,347	5
6	V	32 Interest		Lansing Healthcare Properties	100.00%	116,611	116,611	6
7	V	06 Sign Rental Income	37,440	Lansing Healthcare Properties	100.00%		(37,440)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 683,665			\$ 508,423	\$ * (175,242)	14

* 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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 135	\$	135	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	300		300	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	280		280	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,149		1,149	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	1,783		1,783	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,315		1,315	20
21	V	19 Professional Fees	147,187	Extended Care Consulting, LLC	100.00%	5,689		(141,498)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,126		1,126	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	9,212		9,212	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	35		35	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	205		205	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	452		452	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,302		2,302	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	33,845		33,845	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,110		1,110	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	1,926		1,926	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,360		1,360	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 147,187			\$ 62,224	\$ *	(84,963)	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	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,367	\$	4,367	15
16	V	06 Maintenance (Direct)	5,371	Extended Care Consulting, LLC	100.00%	5,371			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	747		747	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	898		898	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	4,768		4,768	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	71,720		71,720	20
21	V	21 Office and Clerical (Direct)	25,895	Extended Care Consulting, LLC	100.00%	25,895			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	12,271		12,271	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,328		4,328	23
24	V	22 Employee Benefits	5,226	Extended Care Consulting, LLC	100.00%			(5,226)	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		\$ 36,492			\$ 130,365	\$ *	93,873	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 31	\$	31	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	74		74	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	10		10	17
18	V	19 Professional Fees	46,370	Extended Care Clinical, LLC	100.00%	640		(45,730)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	4		4	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	544		544	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	540		540	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	27		27	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	510		510	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	6,160		6,160	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	121		121	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	2,341		2,341	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	340		340	27
28	V	10 Nursing Salary	21,303	Extended Care Clinical, LLC	100.00%	37,242		15,939	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	916		916	29
30	V	12 Social Service Salary	5,999	Extended Care Clinical, LLC	100.00%	10,929		4,930	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,752		6,752	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	20,791		20,791	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	4,118		4,118	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	3,612		3,612	34
35	V	22 Employee Benefits	7,174	Extended Care Clinical, LLC	100.00%			(7,174)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 80,846			\$ 95,702	\$ *	14,856	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	20,975	Xcel Supply, LLC	100.00%	19,049	(1,926)	16
17	V	4 Laundry	3,800	Xcel Supply, LLC	100.00%	3,451	(349)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	68,987	Xcel Supply, LLC	100.00%	62,651	(6,335)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service	1,502	Xcel Supply, LLC	100.00%	1,364	(138)	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	31,452	Xcel Supply, LLC	100.00%	28,564	(2,888)	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		\$ 126,715			\$ 115,079	\$ * (11,636)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 88,820	\$ 88,820	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	88,820	CCS Employee Benefits Group	100.00%		(88,820)	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		\$ 88,820			\$ 88,820	\$ *	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	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 2,358	\$	2,358	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	129		129	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	200		200	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	10		10	18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	133		133	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	6,136		6,136	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	1,033		1,033	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	5,989		5,989	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,082		1,082	23
24	V	21 Office and Clerical	7,358	Vent Lease, LLC.	100.00%			(7,358)	24
25	V	39 Ancillary	23,960	Vent Lease, LLC.	100.00%			(23,960)	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		\$ 31,318			\$ 17,070	\$ *	(14,248)	39

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

Facility Name & ID Number

Tri-State Nsg & Rehab Ctr

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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%	\$ 1,745	\$	1,745	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%	132		132	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	101		101	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	141		141	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	58		58	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	717		717	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	108		108	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	269		269	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%				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%	1,238		1,238	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	13		13	28
29	V	01 Dietary	7,611	Care Centers Health Systems, Inc.	100.00%	3,038		(4,573)	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	6	Care Centers Health Systems, Inc.	100.00%	2		(4)	32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%				33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%				34
35	V	39 Ancillary	12,442	Care Centers Health Systems, Inc.	100.00%	4,967		(7,475)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	3,790		3,790	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	3,869		3,869	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,654		1,654	38
39	Total		\$ 20,059			\$ 22,119	\$ *	2,060	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: 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		
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 Nsg & Rehab Ctr

#

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	0.60	2.00%	Mgmt Fees	\$ 4,200	17-3	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.10	2.00%	AI Sal/AI Fee	3,318	17-7	2
3	Adam Vales	Owner	Clerical	4.76%	See Attached	0.52	1.30%	Alloc. Salary	932	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,450		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 Nsg & Rehab Ctr

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Nsg & Rehab Ctr

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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	30	\$ 6,770	\$	27,420	\$ 135	1
2	02	Food	Patient Days	30	15,058		27,420	300	2
3	03	Housekeeping	Patient Days	30	14,059		27,420	280	3
4	05	Utilities	Patient Days	30	57,646		27,420	1,149	4
5	06	Maintenance	Patient Days	30	89,465		27,420	1,783	5
6	17	Administrative	Patient Days	30	66,000		27,420	1,315	6
7	19	Professional Fees	Patient Days	30	285,482		27,420	5,689	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		27,420	1,126	8
9	21	Office and Clerical	Patient Days	30	462,313		27,420	9,212	9
10	24	Seminar and Travel	Patient Days	30	1,768		27,420	35	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		27,420	205	11
12	26	Insurance	Patient Days	30	22,668		27,420	452	12
13	30	Depreciation	Patient Days	30	115,549		27,420	2,302	13
14	32	Interest	Patient Days	30	1,698,489		27,420	33,845	14
15	33	Real Estate Taxes	Patient Days	30	55,709		27,420	1,110	15
16	34	Rent - Building	Patient Days	30	96,636		27,420	1,926	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		27,420	1,360	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 62,224	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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	30	219,177	219,177	27,420	4,367	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905		5,371	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		27,420	747	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464		898	4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	27,420	4,768	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	27,420	71,720	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			25,895	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	27,420	12,271	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	27,420	4,328	9
10	22	Employee Benefits							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				\$ 5,530,203	\$ 4,838,529		\$ 130,365	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

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	03	Housekeeping	Patient Days	30	\$ 1,549	\$	27,420	\$ 31	1
2	05	Utilities	Patient Days	30	3,693		27,420	74	2
3	06	Maintenance	Patient Days	30	477		27,420	10	3
4	19	Professional Fees	Patient Days	30	32,105		27,420	640	4
5	20	Dues and Subscriptions	Patient Days	30	213		27,420	4	5
6	21	Office & Clerical	Patient Days	30	27,296		27,420	544	6
7	24	Travel and Seminar	Patient Days	30	27,079		27,420	540	7
8	26	Insurance	Patient Days	30	1,342		27,420	27	8
9	30	Depreciation	Patient Days	30	25,586		27,420	510	9
10	32	Interest	Patient Days	30	309,136		27,420	6,160	10
11	33	Real Estate Taxes	Patient Days	30	6,053		27,420	121	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	27,420	2,341	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		27,420	340	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	27,420	15,939	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	27,420	916	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	27,420	4,930	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		27,420	3,159	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	27,420	20,791	18
19	21	Office Salary	Patient Days	30	206,680	206,680	27,420	4,118	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		27,420	3,612	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	27,420	21,303	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		5,999	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			3,593	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 95,702	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					19,049	2
3	4	Laundry	Direct Allocation					3,451	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					62,651	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation					1,364	7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					28,564	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				\$	\$		\$	115,079

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 88,820	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				\$	\$		\$ 88,820	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	Direct Billing	821,185	26	\$ 80,807	\$ 23,960	\$ 2,358	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	23,960	129	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	23,960	200	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	23,960	10	4
5	26	Insurance	Direct Billing	821,185	26	4,573	23,960	133	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	23,960	6,136	6
7	32	Interest	Direct Billing	821,185	26	35,420	23,960	1,033	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	27,420	5,989	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	27,420	1,082	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					\$ 706,114	\$	\$ 17,070	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	3,421,940	26	72,652	82,199	1,745	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		82,199		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	82,199	132	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	82,199	101	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	82,199	141	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	82,199	58	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	82,199	717	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	82,199	108	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	82,199	269	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	82,199	277	10
11	32	Interest	Gross Billable Income	3,421,940	26		82,199		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		82,199		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	82,199	1,238	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	82,199	13	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445	7,611	3,038	15
16	02	Food	Direct Billable Income	2,784	26	1,111			16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182	6	2	18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	12,442	4,967	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	3,790	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	3,869	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	82,199	1,654	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 22,119	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Nsg & Rehab Ctr

0041186

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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 Nsg & Rehab Ctr

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 1,380,096		\$ 90,250	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	DIAWA Loan		X	Line of Credit				669,706		49,684	6									
7	Fairfax HC Properties	X						260,000		26,361	7									
8	See Supplemental Schedule									42,120	8									
9	TOTAL Facility Related				\$22,010.00		\$ 2,620,000	\$ 2,309,802		\$ 208,415	9									
B. Non-Facility Related*																				
10	Interest Income		X							(17,048)	10									
11											11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		\$ (17,048)	14									
15	TOTALS (line 9+line14)						\$ 2,620,000	\$ 2,309,802		\$ 191,367	15									

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Tri-State Nsg & Rehab Ctr

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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																			
	Working Capital																			
8	Allocated From EC Consult.		X				\$	\$			\$	33,845	8							
9	Allocated From EC Clinical		X									6,160	9							
10	Allocated From Vent Lease		X									2,115	10							
11													11							
12													12							
13													13							
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$		15							
16													16							
17													17							
18													18							
19													19							
20	TOTAL Non-Facility Related																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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>	<u>1</u>
2	<u>Allocated From EC Consulting 2201 Main/EC Clinical 2201 Main</u>			<u>7,313</u>	<u>2</u>
3	TOTALS			\$ <u>92,299</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1995	24,431		20	1,222	1,222	17,432	9
10	Various		1996	82,791		20	4,140	4,140	56,831	10
11	Various		1997	44,854		20	2,245	2,245	28,071	11
12	Various		1998	47,497		20	2,271	2,271	29,080	12
13	Various		1999	39,389		20	1,972	1,972	21,119	13
14	Various		2000	13,995		20	701	701	6,617	14
15	Various		2001	20,621		20	1,033	1,033	8,955	15
16	Various		2002	8,353		20	643	643	5,778	16
17	Various		2003	20,578		20	1,557	1,557	10,254	17
18	Various		2004	61,438		20	5,979	5,979	35,535	18
19	Various		2005	140,855		20	13,970	13,970	59,592	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

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	Related Building Company (Pages 12F & 12G)	2,939,184	75,180		146,959	71,779	2,101,711	67
68	Related Party Allocations (Pages 12H & 12I)	28,936	1,978		1,978		12,038	68
69	Financial Statement Depreciation		44,392			(44,392)		69
70	TOTAL (lines 4 thru 69)	\$ 3,472,922	\$ 121,550		\$ 184,671	\$ 63,121	\$ 2,393,013	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 3,472,922	\$ 121,550		\$ 184,671	\$ 63,121	\$ 2,393,013	1
2	Painting Project	2006	1,935		20	194	194	742	2
3	Ice Cream Dipping Cabinet	2006	1,769		20	177	177	663	3
4	Painting Project	2006	6,979		20	698	698	2,617	4
5	Painting Project	2006	116		20	12	12	44	5
6	Duct Detectors	2006	649		20	65	65	238	6
7	Paint	2006	411		20	41	41	151	7
8	Paint	2006	124		20	12	12	45	8
9	Painting Project	2006	2,154		20	215	215	790	9
10	June Ho Payroll	2006	2,836		20	284	284	1,016	10
11	Roof Repair	2006	1,500		20	150	150	600	11
12	Paint	2006	755		20			755	12
13	Suburban Cost	2006	1,850		20	123	123	381	13
14	Boiler Repairs	2006	1,840		20	92	92	368	14
15	Replacement Of Heat Exchanger	2006	2,170		20	109	109	436	15
16	Painting / Decorating	2006	1,941		20	97	97	5,920	16
17	Undercoater And Paint	2006	1,187		20	119	119	337	17
18	Sprinkler System Repair	2006	1,079		20	108	108	297	18
19	New Phone System	2007	9,291		20	929	929	2,400	19
20	Painting (Transfer Expense From Home Office)	2007	9,146		20			9,146	20
21	Carpeting	2007	2,855		20	408	408	1,054	21
22	New Ceilings & Drywall	2007	10,400		20	2,080	2,080	5,373	22
23	Hvac Service	2007	4,584		20	917	917	2,368	23
24	Painting (Transfer Expense From Home Office)	2007	10,101		20	1,010	1,010	2,357	24
25	Painting (Transfer Expense From Home Office)	2007	14,393		20	1,439	1,439	3,238	25
26	New Air Compressor	2007	4,095		20	410	410	921	26
27	New Condensing Unit	2007	2,866		20	287	287	645	27
28	Painting (Transfer Expense From Home Office)	2007	14,349		20	1,435	1,435	3,109	28
29	Painting (Transfer Expense From Home Office)	2007	14,068		20			14,068	29
30	White Vinyl Wall Panels	2007	6,191		20			6,191	30
31	Painting (Transfer From Home Office)	2008	5,208		20			5,208	31
32	Install Fire Alarms & New Smoke Detectors	2008	3,335		20	476	476	953	32
33	14 Coaxial Cable Runs	2008	2,602		20	260	260	499	33
34	TOTAL (lines 1 thru 33)		\$ 3,615,701	\$ 121,550		\$ 196,817	\$ 75,267	\$ 2,465,942	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 3,615,701	\$ 121,550		\$ 196,817	\$ 75,267	\$ 2,465,942	1
2	Painting (Transfer From Home Office)	2008	5,424		20	904	904	5,424	2
3	Painting (Transfer From Home Office)	2008	10,282		20	2,571	2,571	10,282	3
4	Painting (Transfer From Home Office)	2008	5,909		20	1,970	1,970	5,909	4
5	Painting (Transfer From Home Office)	2008	5,302		20	2,209	2,209	5,302	5
6	2 New Laundry Rooms-Electrical, Tiles, Plumbing, Walls	2008	15,900		20	1,590	1,590	2,385	6
7	New Condensing Unit	2008	3,503		20	350	350	525	7
8	Telephone System Upgrade	2008	4,299		20	430	430	609	8
9	Shower Room-Plumbing, Tiles, Wall, Electrical, Fixtures	2008	10,500		20	1,050	1,050	1,313	9
10	Heating Repairs	2008	2,644		20	264	264	308	10
11	Heating Repairs	2008	11,201		20	1,120	1,120	1,307	11
12	Hvac Repairs	2009	23,976		20	1,199	1,199	1,199	12
13	Electrical Conduit Repair	2009	6,250		20	313	313	313	13
14	Plumbing Repairs	2009	5,300		20	133	133	133	14
15	Roof	2009	10,575		20	264	264	264	15
16	Refund Of Insurance Proceeds - Ceiling Cave In	2009	(5,392)		20	(539)	(539)	(539)	16
17	Landmark Adjustment - Ceiling	2009	(15,000)		20	(1,500)	(1,500)	(1,500)	17
18	Walk In Cooler	2009	3,066		20	26	26	26	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)		\$ 3,719,440	\$ 121,550		\$ 209,171	\$ 87,621	\$ 2,499,202	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 3,719,440	\$ 121,550		\$ 209,171	\$ 87,621	\$ 2,499,202	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)		\$ 3,719,440	\$ 121,550		\$ 209,171	\$ 87,621	\$ 2,499,202	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1		\$ 3,719,440	\$ 121,550		\$ 209,171	\$ 87,621	\$ 2,499,202	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)	\$ 3,719,440	\$ 121,550		\$ 209,171	\$ 87,621	\$ 2,499,202	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Building Company Information								1
2	Buildings:								2
3	84 Beds	1962	2,932,035	75,180	39	146,602	71,422	2,101,294	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Heating Repairs	2008	7,149		20	357	357	417	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Tri-State Nsg & Rehab Ctr**

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,939,184	\$ 75,180		\$ 146,959	\$ 71,779	\$ 2,101,711

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	9,078	233	39	233		1,697	3
4	Allocated From Extended Care Clinical 2201 Main	2002	1,000	26	39	26		187	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	92	2	20	2		11	9
10	Allocated From Extended Care Consulting	2009	55	3	20	3		3	10
11									11
12	Allocated From Extended Care Consulting 2201 Main	2002	7,499	685	20	685		4,118	12
13	Allocated From Extended Care Consulting 2201 Main	2003	8,837	808	20	808		4,854	13
14	Allocated From Extended Care Consulting 2201 Main	2005	439	47	20	47		158	14
15	Allocated From Extended Care Consulting 2201 Main	2009	79	4	20	4		4	15
16									16
17	Allocated From Extended Care Clinical 2201 Main	2002	826	76	20	76		454	17
18	Allocated From Extended Care Clinical 2201 Main	2003	974	89	20	89		535	18
19	Allocated From Extended Care Clinical 2201 Main	2005	48	5	20	5		17	19
20	Allocated From Extended Care Clinical 2201 Main	2009	9		20				20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 28,936	\$ 1,978		\$ 1,978	\$	\$ 12,038	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 182,190	\$ 28,642	\$ 16,908	\$ (11,734)	10	\$ 141,915	71
72	Current Year Purchases	10,755	1,116	1,117	1	10	1,117	72
73	Fully Depreciated Assets	345,170				10	345,170	73
74								74
75	TOTALS	\$ 538,115	\$ 29,758	\$ 18,025	\$ (11,733)		\$ 488,202	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		Alloc. From EC Consulting	2009	6,408	100	100		5	6,107	77
78		Alloc. From EC Clinical	2009	1,432	286	286		5	844	78
79		Alloc. From EC Health Systems	2009	704	141	141		5	212	79
80	TOTALS			\$ 55,752	\$ 527	\$ 527	\$		\$ 42,571	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)	\$ 4,405,606	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,835	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 227,723	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 75,888	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,029,975	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section 754 Building - 1999	\$ 45,464	\$ 1,166	\$ 12,290	86
87	Section 754 Land - 1999	5,051			87
88	Section 754 Land - 2000	1,950			88
89	Section 754 Land - 2001	9,828			89
90					90
91	TOTALS	\$ 62,293	\$ 1,166	\$ 12,290	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.

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? YES NO

If NO, see instructions.

	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 Unit Rental</u>		<u>1,533</u>			4
5		<u>Allocated From Extended Care Consulting</u>		<u>1,926</u>			5
6		<u>Allocated From Extended Care Health Systems</u>		<u>1,238</u>			6
7	TOTAL			\$ <u>4,697</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 4,275 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

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	\$		\$ 224,275	\$		\$ 224,275	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			84,262			84,262	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			263,187			263,187	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				226,104		226,104	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>					37,034	128,545		165,579	13
14	TOTAL			\$		\$ 608,758	\$ 354,649		\$ 963,407	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 Nsg & Rehab Ctr

0041186

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (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	\$ 71,101	1
2	Cash-Patient Deposits	30,548	135,548	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	308,597	308,597	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	146,847	146,847	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	170,000	884,018	8
9	Other(specify): <u>See Attached Schedule</u>	2,640,714	2,784,299	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,297,706	\$ 4,330,410	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	702,966	702,966	15
16	Equipment, at Historical Cost	386,011	555,984	16
17	Accumulated Depreciation (book methods)	(818,328)	(2,075,041)	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)	\$ 270,649	\$ 2,276,449	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,568,355	\$ 6,606,859	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,677,537	\$ 1,677,537	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,387	29,387	28
29	Short-Term Notes Payable	669,706	669,706	29
30	Accrued Salaries Payable	135,393	135,393	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,670	5,670	31
32	Accrued Real Estate Taxes(Sch.IX-B)	254,076	254,076	32
33	Accrued Interest Payable		266,085	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	553,796	802,381	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,325,565	\$ 3,840,235	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		260,000	39
40	Mortgage Payable		1,380,096	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)	\$	\$ 1,640,096	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,325,565	\$ 5,480,331	46
47	TOTAL EQUITY(page 18, line 24)	\$ 242,790	\$ 1,126,528	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,568,355	\$ 6,606,859	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (42,305)	1
2	Restatements (describe):		2
3	Rounding Adjustment	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (42,302)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	285,092	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 285,092	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)	\$ 242,790	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 5,845,101	1
2	Discounts and Allowances for all Levels	(2,624,911)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,220,190	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,343,616	6
7	Oxygen	12,717	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,356,333	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	234,347	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,408	19
20	Radiology and X-Ray	4,300	20
21	Other Medical Services	148,810	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 406,865	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,048	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,048	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	43,833	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 43,833	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,044,269	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	919,631	31
32	Health Care	1,853,239	32
33	General Administration	1,221,517	33
B. Capital Expense			
34	Ownership	754,853	34
C. Ancillary Expense			
35	Special Cost Centers	963,947	35
36	Provider Participation Fee	45,990	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,759,177	40
41	Income before Income Taxes (line 30 minus line 40)**	285,092	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 285,092	43

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

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

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

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

Facility Name & ID Number **Tri-State Nsg & Rehab Ctr**

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,751	1,957	\$ 84,416	\$ 43.14	1
2	Assistant Director of Nursing	1,049	1,171	34,844	29.76	2
3	Registered Nurses	7,442	8,235	215,433	26.16	3
4	Licensed Practical Nurses	20,896	23,388	544,747	23.29	4
5	CNAs & Orderlies	42,992	49,188	497,887	10.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,137	10,271	139,693	13.60	8
9	Activity Director	1,828	2,019	26,976	13.36	9
10	Activity Assistants	6,140	6,840	59,579	8.71	10
11	Social Service Workers	3,798	4,371	84,406	19.31	11
12	Dietician					12
13	Food Service Supervisor	1,854	2,053	41,165	20.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,018	4,831	53,037	10.98	15
16	Dishwashers	10,293	11,651	113,830	9.77	16
17	Maintenance Workers	2,581	2,803	52,388	18.69	17
18	Housekeepers	10,600	12,587	135,637	10.78	18
19	Laundry	5,666	6,948	81,700	11.76	19
20	Administrator	2,210	2,281	91,503	40.12	20
21	Assistant Administrator	136	136	3,786	27.84	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,568	5,064	60,432	11.93	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	1,963	2,317	35,744	15.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	138,922	158,111	\$ 2,357,203 *	\$ 14.91	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	295	\$ 14,078	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	190	10-03	38
39	Pharmacist Consultant	Monthly	1,181	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					47
48	<u>See Attached</u>		27,302		48
49	TOTAL (lines 35 - 48)	295	\$ 51,751		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Marc Halpert(3/3/09-12/31/09)	Administrator	0.00%	\$ 91,503	Workers' Compensation Insurance	\$ 62,532	IDPH License Fee	\$ 995		
Crystal Wray (1/1/09-3/2/09)	Administrator	0.00%	3,786	Unemployment Compensation Insurance	64,952	Advertising: Employee Recruitment	3,780		
				FICA Taxes	175,587	Health Care Worker Background Check	3,500		
				Employee Health Insurance	144,428	(Indicate # of checks performed <u>144</u>)			
				Employee Meals		Patient Background Checks	85 1,251		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	2,101		
				Other Employee Welfare	8,883	Dues & Subscriptions	7,263		
				Holiday Expenses	1,760	Advertising & Promotions	9,393		
				Employee Physicals	800	Allocated From Ext. Care Consulting	1,126		
				Pension Expense	48,488	See Supplemental Schedule	62		
						Less: Public Relations Expense	()		
						Non-allowable advertising	(9,393)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,289	TOTAL (agree to Schedule V, line 22, col.8)	\$ 507,430	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,078		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Eric Rothner Management Fees			\$ 4,200				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 4,200	TOTAL		\$	Seminar Expense	8,499	
C. Professional Services							Allocated From Ext. Care Consulting		35
Vendor/Payee	Type		Amount				Allocated From Ext. Care Clinical		540
Frost, Ruttenberg & Rothblatt	Accounting		\$ 20,267				Entertainment Expense		()
See Attached	Legal		10,340				(agree to Sch. V, line 24, col. 8)		
Personnel Planners	Unemployment Consult		1,224				TOTAL	\$ 9,074	
Extended Care Consulting	Home Office Expenses		143,337						
Extended Care Clinical	Home Office Expenses		46,370						
Allegiance	Employee Compliance		56						
Chad Cournaya	Medicare Consultant		150						
Extended Care Consulting	Other Professional Services		3,850						
Prospect Resources	Natural Gas Procurement		1,950						
Pinnacle Consulting	Customer Satisfaction		2,538						
LaSalle Appraisal Group	Real Estate Appraisal		4,000						
See Supplemental Schedule			15,340						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 249,422						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041186

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$6,728; IL Assoc of HC \$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. \$ 19,780 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 45,990
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100 % Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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
- (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.