FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0055400

Facility Name: Tri State Village Nrsg Rhb

Address: 2500 East 175th St (Number) | Lansing (City) | 60438 (Zip Code)

County: Cook

Telephone Number: 708-474-7330 **Fax #** 708-474-7391

HFS ID Number:

Date of Initial License for Current Owners: 12/01/2018

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider **Telephone Number:** 847-933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) See Accountant's Report Attached (Date)
(Print Name and Title)
(Firm Name & Address) Mendel S Schneider & Associates CPA PC, 4051 Old Orchard Rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 _____

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF	9,431		1,761		2,092	1,875	1,657	16,816	8
9	SNF/PED									9
10	ICF		11,407						11,407	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	9,431	11,407	1,761		2,092	1,875	1,657	28,223	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.05%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2018 NO [ ]

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

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	400,945	33,708	10,710	445,363		445,363		445,363			1
2	Food Purchase		258,708		258,708		258,708	(850)	257,858			2
3	Housekeeping	207,855	91,445	33,230	332,530		332,530		332,530			3
4	Laundry	141,888	2,095		143,983		143,983		143,983			4
5	Heat and Other Utilities			104,081	104,081		104,081	1,921	106,002			5
6	Maintenance	187,010		100,306	287,316		287,316	3,273	290,589			6
7	Other (specify):*											7
8	**TOTAL General Services**	937,698	385,956	248,327	1,571,981		1,571,981	4,344	1,576,325			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,590,812	346,695	5,952	3,943,459		3,943,459		3,943,459			10
10a	Therapy											10a
11	Activities	165,308	15,183		180,491		180,491		180,491			11
12	Social Services	71,883	544		72,427		72,427		72,427			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,828,003	362,422	23,952	4,214,377		4,214,377		4,214,377			16
	C. General Administration											
17	Administrative	143,900		499,531	643,431		643,431	(499,531)	143,900			17
18	Directors Fees											18
19	Professional Services			220,889	220,889		220,889	(17,755)	203,134			19
20	Dues, Fees, Subscriptions & Promotions			65,293	65,293		65,293	(13,201)	52,092			20
21	Clerical & General Office Expenses	409,652	152,277	144,697	706,626		706,626	30,245	736,871			21
22	Employee Benefits & Payroll Taxes			714,916	714,916		714,916		714,916			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,706	1,706		1,706		1,706			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			249,701	249,701		249,701	551	250,252			26
27	Other (specify):* **Allocated Benefits**							14,737	14,737			27
28	**TOTAL General Administration**	553,552	152,277	1,896,733	2,602,562		2,602,562	(484,954)	2,117,608			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,319,253	900,655	2,169,012	8,388,920		8,388,920	(480,610)	7,908,310			29

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

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

Facility Name & ID Number Tri State Village Nrsg Rhb #0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			55,883	55,883		55,883	(19,430)	36,453			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			654,924	654,924		654,924		654,924			33
34	Rent-Facility & Grounds			473,083	473,083		473,083	2,001	475,084			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Bad Debt**			149,812	149,812		149,812	(149,812)				36
37	**TOTAL Ownership**			1,333,702	1,333,702		1,333,702	(167,241)	1,166,461			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		304,673	341,751	646,424		646,424		646,424			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			523,981	523,981		523,981		523,981			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		304,673	865,732	1,170,405		1,170,405		1,170,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,319,253	1,205,328	4,368,446	10,893,027		10,893,027	(647,851)	10,245,176			45

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,430)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(850)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(36,282)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(86,049)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(149,812)	36		24
25	Fund Raising, Advertising and Promotional	(8,595)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (301,018)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(342,227)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (342,227)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (643,245)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Tri State Village Nrsg Rhb

ID# 0055400

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (4,606)	20	1
2	Other Expenses Related to Lobbying Activities			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				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**	(4,606)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(850)	0	0	0	0	0	0	0	0	0	0	(850)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,921	0	0	0	0	0	0	0	0	1,921	5
6	Maintenance	0	0	3,273	0	0	0	0	0	0	0	0	3,273	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(850)	0	5,194	0	0	0	0	0	0	0	0	4,344	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(499,531)	0	0	0	0	0	0	0	0	(499,531)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(86,049)	0	68,294	0	0	0	0	0	0	0	0	(17,755)	19
20	Fees, Subscriptions & Promotions	(13,201)	0	0	0	0	0	0	0	0	0	0	(13,201)	20
21	Clerical & General Office Expenses	(36,282)	0	66,527	0	0	0	0	0	0	0	0	30,245	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	551	0	0	0	0	0	0	0	0	551	26
27	Other (specify):*	0	0	14,737	0	0	0	0	0	0	0	0	14,737	27
28	TOTAL General Administration	(135,532)	0	(349,422)	0	0	0	0	0	0	0	0	(484,954)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(136,382)	0	(344,228)	0	0	0	0	0	0	0	0	(480,610)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(19,430)	0	0	0	0	0	0	0	0	0	0	(19,430)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,001	0	0	0	0	0	0	0	0	2,001	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(149,812)	0	0	0	0	0	0	0	0	0	0	(149,812)	36
37	TOTAL Ownership	(169,242)	0	2,001	0	0	0	0	0	0	0	0	(167,241)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(305,624)	0	(342,227)	0	0	0	0	0	0	0	0	(647,851)	45

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 499,531	Jade Financial Services		$	$ (499,531)	15
16	V	21	Office		Jade Financial Services		18,550	18,550	16
17	V	19	Professional Fees		Jade Financial Services		68,294	68,294	17
18	V	5	Utilities		Jade Financial Services		1,921	1,921	18
19	V	6	Repairs & Maintenance		Jade Financial Services		3,273	3,273	19
20	V	34	Rent		Jade Financial Services		2,001	2,001	20
21	V	21	Clerical Wages		Jade Financial Services		47,977	47,977	21
22	V	27	Allocated Benefits		Jade Financial Services		14,737	14,737	22
23	V	26	Insurance		Jade Financial Services		551	551	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			$ 499,531			$ 157,304	$ * (342,227)	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Tri State Village Nrsg Rhb

ID# **0055400**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Jake	0	Mashiach	Chicago	Il	20.00000			1
2	Yechiel	0	Mashiach	Lincolnwood	Il	20.00000			2
3	Rhonda	0	Mashiach	Lincolnwood	Il	20.00000			3
4	Rita	0	Lipshitz	Skokie	Il	20.00000			4
5	Atied Associates, LLC	0	0	0	0	0.00000			5
6	B&Z Grandchildren Tru	0	0	0	0	0.00000			6
7	Benificiaries	0	0	0	0	0.00000			7
8	Rebecca	0	Rudolph	Evanston	Il	0.23077			8
9	Michael	0	Rudolph	Evanston	Il	0.23077			9
10	Zahava	0	Vales	Evanston	Il	0.23077			10
11	Raban	0	Vales	Evanston	Il	0.23077			11
12	Natan	0	Vales	Deerfield	Il	0.23077			12
13	Amidei	0	Vales	Deerfield	Il	0.23077			13
14	Cary	0	Silvers	Evanston	Il	0.23077			14
15	Jonathan	0	Silvers	Highland Park	Il	0.23077			15
16	Jacob	0	Silvers	Highland Park	Il	0.23077			16
17	Noam	0	Rothner	Teaneck	NJ	0.23077			17
18	Yonit	0	Rothner	Teaneck	NJ	0.23077			18
19	Hanna	0	Levine	Skokie	Il	0.23077			19
20	Nathan	0	Levine	Evanston	IL	0.23077			20
21	Nathan & Shirley Rothn	0	0	0	0	0.00000			21
22	Benificiaries	0	0	0	0	0.00000			22
23	Melisa	0	Rothner	Skokie	Il	0.75000			23
24	Daniel	0	Rothner	Teaneck	NJ	0.75000			24
25	William	0	Rothner	Skokie	Il	0.75000			25
26	Rachel	0	Rothner	Beachwood	OH	0.75000			26
27	0	0	0	0	0	0.00000			27
28	Daniel Rothner Accumu	0	0	0	0	0.00000			28
29	Benificiaries	0	0	0	0	0.00000			29
30	Daniel	0	Rothner	Teaneck	NJ	1.00000			30
31	William RothnerAccumu	0	0	0	0	0.00000			31
32	Benificiaries	0	0	0	0	0.00000			32
33	William	0	Rothenr	Skokie	IL	1.00000			33
34	Mellisa Rothner Accumu	0	0	0	0	0.00000			34
35	Benificiaries	0	0	0	0	0.00000			35
36	Mellisa	0	Rothner	Skokie	IL	1.00000			36
37	Rachel Rothner Accumu	0	0	0	0	0.00000			37
38	Rachel	0	Rothner	Beachwood	OH	1.00000			38
39	Adam Vales Accumulati	0	0	0	0	0.00000			39
40	Adam	0	Vales	Deerfield	Il	1.00000			40
41	Kathryn Vales Accumul	0	0	0	0	0.00000			41
42	kathryn	0	Vales	Highland park	Il	1.00000			42
43	Kimberly Vales Accumu	0	0	0	0	0.00000			43
44	Kimberly	0	Vales	Highland Park	Il	1.00000			44
45									45
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STATE OF ILLINOIS **Ownership Listing-2**

Tri State Village Nrsg Rhb

ID# **0055400**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76	Melisa	0	Rothner	Skokie	Il	1.00000			76
77	Daniel	0	Rothner	Teaneck	NJ	1.00000			77
78	William	0	Rothner	Skokie	Il	1.00000			78
79	Rachel	0	Rothner	Beachwood	OH	1.00000			79
80	Adam	0	Vales	Deerfield	Il	1.00000			80
81	Kathryn	0	Silvers	Highland Park	Il	1.00000			81
82	Kimberly	0	Rudolph	Highland Park	Il	1.00000			82
83									83
84									84
85									85
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149									149
150									150

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.**

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Arista Healthcare	Naperville	SALEM NURSING & REHABILITATION CE	Joliet	Jade Financial Service	Skokie, Illinois	Mgmt	1
2	Forest City Nursing & Rehab	Rockford	NORTHVIEW VILLAGE INC.	St. Louis				2
3	Rock River Healthcare	Rockford	CHATEAU NURSING & REHABILITATION (	Willowbrook				3
4	Pearl Pavillion	Freeport	GRASMERE PLACE LLC	Chicago				4
5	Parc Of Joliet	Joliet	LAKEWOOD NURSING & REHABILITATIO	Plainfield				5
6	Spring Creek SNF	Joliet	LEMONT NURSING & REHABILITATION C	Lemont				6
7	Chicago Ridge SNF	Chicago ridge	PRARIE MANOR NURSING & REHABILITA	Chicago Heights				7
8	Briar place	Indian Head park	FOOTHILLS REHABILITATION CENTER LI	Tucson				8
9	ELMWOOD NURSING & REHABILITATION	Maryville	MCKINLEY HEALTH CARE CENTER LLC	Canton				9
10	CRESTWOOD REHABILITATION CENTER I	Crestwood	DEVON GABLES REHABILITATION CENTE	Tucson				10
11	KENSINGTON NURSING AND REHABILITA	Chicago	ST. JAMES WELLNESS REHAB & VILLAS L	Crete				11
12	ABBINGTON VILLAGE NURSING AND REH	Roselle	KENSINGTON NURSING HOLDINGS LLC	Chicago				12
13	ALL AMERICAN NURSING AND REHABILI	Chicago	ESTATES OF HYDE PARK LLC	Chicago				13
14	HICKORY VILLAGE NURSING AND REHAB	Hickory Hills	PONTIAC HEALTHCARE AND REHAB LLC	Pontiac				14
15	HENRY FORD VILLAGE LLC	Dearborn	PINE CREST HEALTH CARE LLC	Hazelcrest				15
16	westwood Village Nursing & Rehab center	Chicago	APERION CARE KOKOMO LLC	Kokomo				16
17	JB KENOSHA LLC	Kenosha	APERION CARE PERU LLC	Peru				17
18	EDGEWATER CARE & REHABILITATION C	Chicago	APERION CARE TOLLESTON PARK LLC	Gary				18
19	Little Village Nursing & rehab Center	Chicago	APERION CARE DEMOTTE LLC	East Demotte				19
20	RUSHVILLE NURSING REHABILITATION C	Rushville	RUSHVILLE NURSING REHABILITATION (	Rushville				20
21	NEIGHBORS REHABILITATION CENTER LI	Byron	BRIDGEWAY SENIOR LIVING LLC	Bensenville				21
22	CHAMPAIGN REHABILITATION CENTER L	Champaign	PARK VILLA NURSING & REHABILITATIO	Palos Heights				22
23	Sheridan Village Nursing & Rehab Center	Chicago	WESTMONT MANOR HRC LLC	Westmont				23
24	WESTWOOD VILLAGE NURSING AND REH	Chicago	SOUTH HOLLAND MANOR LLC	South Holland				24
25	Wheaton Village & Nursing Center	Wheaton	UNIVERSITY REHABILITATION CENTER C	Urbana				25
26	0	0	PALOS HEIGHTS REHABILITATION LLC	Crestwood				26
27	0	0	BURBANK REHABILITATION CENTER LLC	Burbank				27
28	0	0	COUNTRYSIDE NURSING & REHABILITAT	Dolton				28
29								29
30								30

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Jade Financial Services LLC
Street Address: 8707 Skokie Blvd
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847-213-1060
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Office	Number of Beds	1,231	10	$ 271,852	$	84	$ 18,550	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830		84	68,294	2
3	5	Utilities	Number of Beds	1,231	10	28,149		84	1,921	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967		84	3,273	4
5	34	Rent	Number of Beds	1,231	10	29,319		84	2,001	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	84	47,977	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961		84	14,737	7
8	26	Insurance	Number of Beds	1,231	10	8,068		84	551	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					$ 2,305,240	$ 703,094		$ 157,304	25

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

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

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	412,290	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	502,980	2
3. Under or (over) accrual (line 2 minus line 1).	$	90,690	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$	528,129	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	36,105	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	654,924	7

Assessed Value from Real Estate Tax Bill:	2024	981,287	8
Real Estate Tax Bill for Calendar Year:	2020	432,936	9
	2021	466,487	10
	2022	379,279	11
	2023	392,657	12
	2024	502,980	13

Line 4: 502980 x 1.05

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri State Village Nrsg Rhb COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055400

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE 847-933-1274 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-30-305-035-0000		$ 502,979.61	$ 502,979.61
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 502,979.61	$ 502,979.61

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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).**

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

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

K. **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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Rtu Repairs-PT Room-New Blower Assembly			2019	2,544		20	127	127	889	9
10	Fire Sprinkler System Repair-Dry Pendant Heads			2019	14,619		20	731	731	5,117	10
11	Fire Sprinkler System Repair-Sprinkler Head Replacement			2019	28,976		20	1,449	1,449	10,143	11
12	Replacement of Ceiling in Main Lobby			2020	29,688		20	1,484	1,484	8,904	12
13	Repairs to Walk In Freezer			2020	3,510		20	176	176	1,056	13
14	Replace 2 Air Handlers,Duct Connection			2021	19,800		20	990	990	4,950	14
15	Magnetic Locks on Doors			2021	26,676		20	1,334	1,334	6,670	15
16	Replace Compressor			2022	4,337		20	217	217	868	16
17	Replace Damaged Water Pipe for Hot Water Line			2022	4,700		20	235	235	940	17
18	Installation of 18 New Cameras			2022	15,039		20	752	752	3,008	18
19	Remove Rod Cable From Trap, Install New Section of Drain			2022	3,800		20	190	190	760	19
20	New Water Heater			2023	22,000		15	1,467	1,467	4,401	20
21	New Circulating Pump			2023	4,000		15	267	267	801	21
22	New Washing Machines & Installation			2023	24,235		15	1,616	1,616	4,848	22
23	New Mixing Valve for Hot Water Heater			2024	7,992		15	533	533	1,066	23
24	New Blower & Motor Control on HVAC			2024	4,971		15	331	331	662	24
25	New Gas Line Pipe West Units			2024	10,900		15	727	727	1,454	25
26	Fire System Sprinkler Repair			2024	7,088		15	473	473	946	26
27	New Roof			2024	197,239		15	13,150	13,150	26,300	27
28	Replacement of Walk In Freezer Door			2025	7,367		15	491	491	491	28
29	Replace Mixing Valve in Hot Water Tank			2025	3,035		15	202	202	202	29
30	A/C Repairs			2025	3,521		15	235	235	235	30
31	Replace Water Heater & Pipes in Boiler			2025	6,702		15	447	447	447	31
32	Removing Floor & Tile in Shower Rooms			2025	92,280		15	6,152	6,152	6,152	32
33	Install Tile in Twin Resident Rooms			2025	6,250		15	417	417	417	33
34											34
35	Financial Statement Depreciation					55,883			(55,883)		35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 551,269	$ 55,883		$ 34,193	$ (21,690)	$ 91,727	70

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 22,602	$	$ 2,260	$ 2,260	10	$ 9,760	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	62,364					62,364	73
74								74
75	TOTALS	$ 84,966	$	$ 2,260	$ 2,260		$ 72,124	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 636,235	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,883	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,453	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,430)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 163,851	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Lansing Healthcare Properties LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 473,083			3
4	Additions							4
5								5
6	Allocated from Jade				2,001			6
7	TOTAL				$ 475,084 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 138,354	$		$ 138,354	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			44,944			44,944	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			158,453			158,453	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				107,554		107,554	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					197,119		197,119	12
13	Other (specify):									13
14	TOTAL			$		$ 341,751	$ 304,673		$ 646,424	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.

STATE OF ILLINOIS

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2025 (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	$ 387,958	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,366,159		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	330,810		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrows	267,139		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,352,066	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	503,995		15
16	Equipment, at Historical Cost	116,849		16
17	Accumulated Depreciation (book methods)	(222,502)		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): Security Deposit	121,705		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 520,047	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,872,113	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,852,356	$	26
27	Officer's Accounts Payable	104,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	230,621		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,712		31
32	Accrued Real Estate Taxes(Sch.IX-B)	528,129		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related	4,497,338		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,233,156	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,233,156	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,361,043)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,872,113	$	48

*(See instructions.)

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,609,411)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,609,411)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(751,632)	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)**	$ (751,632)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,361,043)	24 *

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,141,129	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,141,129	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	266	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 266	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,141,395	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,571,981	31
32	Health Care	4,214,377	32
33	General Administration	2,602,562	33
	B. Capital Expense		
34	Ownership	1,333,702	34
	C. Ancillary Expense		
35	Special Cost Centers	646,424	35
36	Provider Participation Fee	523,981	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,893,027	40
41	**Income before Income Taxes (line 30 minus line 40)****	(751,632)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (751,632)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 2,787,010.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,538,600.00	45
46	MMAI-Medicaid is the Primary Payer	514,053.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	555,612.00	48
49	Medicare Part A	1,463,422.00	49
50	Other-(specify) **Medicare-B**	137,000.00	50
51	Other-(specify) **Medicare Advantage**	974,295.00	51
52	Other-(specify) **Misc**	171,137.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,141,129	56

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,024	2,312	$ 152,850	$ 66.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,496	13,102	585,396	44.68	3
4	Licensed Practical Nurses	24,759	26,916	1,105,880	41.09	4
5	CNAs & Orderlies	52,413	57,891	1,594,180	27.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,581	2,126	70,138	32.99	9
10	Activity Assistants	4,176	4,546	95,170	20.93	10
11	Social Service Workers	1,981	2,135	71,883	33.67	11
12	Dietician					12
13	Food Service Supervisor	1,972	2,125	65,469	30.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,672	14,955	335,476	22.43	15
16	Dishwashers					16
17	Maintenance Workers	4,575	5,060	187,010	36.96	17
18	Housekeepers	9,013	9,696	207,855	21.44	18
19	Laundry	6,105	6,626	141,888	21.41	19
20	Administrator	1,832	2,080	143,900	69.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,337	9,083	409,652	45.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,188	2,357	59,063	25.06	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	1,621	1,794	93,443	52.09	33
34	TOTAL (lines 1 - 33)	147,745	162,804	$ 5,319,253 *	$ 32.67	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 10,710	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,952	10-3	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					48
49	TOTAL (lines 35 - 48)		$ 34,662		49

C. CONTRACT NURSES

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

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yehosha Mashiach	Administrator	0	$ 143,900
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,900

B. Administrative - Other

Description	Amount
Jade Financial-Mgmt Fees	$ 499,531
TOTAL (agree to Schedule V, line 17, col. 3)	$ 499,531
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 10,400
Settlement	Adjusted Out	86,049
Neil Gerber Eisenberg	Legal	1,160
Much Shelist	Legal	840
Sher LLP	Legal	8,048
Elizabeth Nash	Reimb Cons	28,800
Guided Care	Case Mgmt	37,750
Goodnicki LLP	Legal	3,932
Ashman & Stein	Legal	6,158
Silver Key	Medicaid Applic	36,000
Personnel Planners	UC Tax Cons	1,752
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 220,889

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,518
Unemployment Compensation Insurance	40,550
FICA Taxes	404,521
Employee Health Insurance	233,327
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 714,916

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	21,652
Health Care Worker Background Check	570
(Indicate # of checks performed)	
Patient Background Checks	820
Association Dues (total from pg 22, #4)	13,818
Netsmart	3,828
RADAR	2,136
Joint Commission	2,490
Various	9,394
Less: Public Relations Expense	( )
PAC and Lobbying payments	(4,606)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,092

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Various	1,706
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,706

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Tri State Village Nrsg Rhb # 0055400 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	9,212
	9,212 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	4,606
	4,606 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	13,818
	13,818 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 52,647 Line 10

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 523,981
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Indicate the amount. $

(12) 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? If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

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