FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0041186

Facility Name: Tri State Nrsing & Rehab Ctr

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: 9/1/1995

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	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 Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,222	1,820	4,420	27,462	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,222	1,820	4,420	27,462	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.57%

D. How many bed-hold days during this year were paid by the Department?
None (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 [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 09/01/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 4,202

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	232,822	35,780	15,031	283,633		283,633	2,831	286,464			1
2	Food Purchase		155,621		155,621		155,621	295	155,916			2
3	Housekeeping	110,479	21,450		131,929		131,929	354	132,283			3
4	Laundry	62,029	10,631		72,660		72,660		72,660			4
5	Heat and Other Utilities			89,274	89,274		89,274	775	90,049			5
6	Maintenance	68,765		192,420	261,185		261,185	7,541	268,726			6
7	Other (specify):*							3,649	3,649			7
8	**TOTAL General Services**	474,095	223,482	296,725	994,302		994,302	15,445	1,009,747			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,665,542	179,165	5,715	1,850,422		1,850,422	25,248	1,875,670			10
10a	Therapy	172,781		82	172,863		172,863		172,863			10a
11	Activities	103,536	20,014		123,550		123,550		123,550			11
12	Social Services	185,023			185,023		185,023	11,445	196,468			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,191	4,191			15
16	**TOTAL Health Care and Programs**	2,126,882	199,179	23,797	2,349,858		2,349,858	40,884	2,390,742			16
	C. General Administration											
17	Administrative	95,239			95,239		95,239	51,788	147,027			17
18	Directors Fees											18
19	Professional Services			374,345	374,345	(2,750)	371,595	(284,996)	86,599			19
20	Dues, Fees, Subscriptions & Promotions			43,358	43,358		43,358	(15,223)	28,135			20
21	Clerical & General Office Expenses	94,533	21,106	155,147	270,786		270,786	(8,663)	262,123			21
22	Employee Benefits & Payroll Taxes			613,089	613,089		613,089	(13,010)	600,079			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,036	2,036		2,036	919	2,955			24
25	Other Admin. Staff Transportation			7,677	7,677		7,677	753	8,430			25
26	Insurance-Prop.Liab.Malpractice			128,205	128,205		128,205	1,114	129,319			26
27	Other (specify):*							20,942	20,942			27
28	**TOTAL General Administration**	189,772	21,106	1,323,857	1,534,735	(2,750)	1,531,985	(246,376)	1,285,609			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,790,749	443,767	1,644,379	4,878,895	(2,750)	4,876,145	(190,047)	4,686,098			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 Nrsing & Rehab Ctr #0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,457	72,457		72,457	166,348	238,805			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76	76		76	60,040	60,116			32
33	Real Estate Taxes			217,958	217,958	2,750	220,708	1,727	222,435			33
34	Rent-Facility & Grounds			378,000	378,000		378,000	(378,000)				34
35	Rent-Equipment & Vehicles			11,083	11,083		11,083	443	11,526			35
36	Other (specify):*											36
37	**TOTAL Ownership**			679,574	679,574	2,750	682,324	(149,442)	532,882			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		294,486	822,467	1,116,953		1,116,953	(970)	1,115,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,707	187,707		187,707		187,707			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		294,486	1,010,174	1,304,660		1,304,660	(970)	1,303,690			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,790,749	738,253	3,334,127	6,863,129		6,863,129	(340,458)	6,522,671			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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	86,788	30		9
10	Interest and Other Investment Income	(27,273)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(103)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,199)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,994)	21		24
25	Fund Raising, Advertising and Promotional	(9,881)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(295)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(36,371)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,328)		$	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)	(273,131)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (273,131)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (340,458)		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

STATE OF ILLINOIS **Page 5A**

Tri State Nrsing & Rehab Ctr

ID# **0041186**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (1,625)	21	1
2	Jury Duty	(17)	10	2
3	Theft Loss	(307)	21	3
4	Collection Expense	(7,808)	21	4
5	PAC Dues	(5,018)	20	5
6	Building Company - Bank Charges	(365)	21	6
7	Building Company - Management Fees	(1,050)	17	7
8	Vacand Lnd R/E Tax	(7,819)	33	8
9	Out of Period Expense	(1,119)	21	9
10	Annual Report	(250)	20	10
11	Non-Allowable Legal	(10,442)	19	11
12	Building Company - Legal Fees	(551)	19	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**	(36,371)		49

STATE OF ILLINOIS **Page 5B**

Tri State Nrsing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			89		2,742							2,831	1
2	Food Purchase	(103)		398									295	2
3	Housekeeping			298		56							354	3
4	Laundry													4
5	Heat and Other Utilities			672		103							775	5
6	Maintenance			2,773	4,683	85							7,541	6
7	Other (specify):*				3,336	313							3,649	7
8	**TOTAL General Services**	(103)		4,230	8,019	3,299							15,445	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)				25,265							25,248	10
10a	Therapy													10a
11	Activities													11
12	Social Services					11,445							11,445	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,191							4,191	15
16	**TOTAL Health Care and Programs**	(17)				40,901							40,884	16
	C. General Administration													
17	Administrative	(1,050)	1,050	1,843	9,966	39,979							51,788	17
18	Directors Fees													18
19	Professional Services	(10,993)	551	(205,008)		(69,546)							(284,996)	19
20	Fees, Subscriptions & Promotions	(16,348)		979		146							(15,223)	20
21	Clerical & General Office Expenses	(90,513)	365	6,705	58,474	16,306							(8,663)	21
22	Employee Benefits & Payroll Taxes				(13,010)								(13,010)	22
23	Inservice Training & Education													23
24	Travel and Seminar			153		766							919	24
25	Other Admin. Staff Transportation			753									753	25
26	Insurance-Prop.Liab.Malpractice			809		305							1,114	26
27	Other (specify):*				14,613	6,329							20,942	27
28	**TOTAL General Administration**	(118,904)	1,966	(193,766)	70,043	(5,715)							(246,376)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(119,024)	1,966	(189,536)	78,062	38,485							(190,047)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri State Nrsing & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	86,788	76,346	2,494		720							166,348	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(27,273)	66,332	571		20,410							60,040	32
33	Real Estate Taxes	(7,819)	7,819	1,453		274							1,727	33
34	Rent-Facility & Grounds		(378,000)										(378,000)	34
35	Rent-Equipment & Vehicles			443									443	35
36	Other (specify):*													36
37	**TOTAL Ownership**	51,696	(227,503)	4,961		21,404							(149,442)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(970)						(970)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(970)						(970)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,328)	(225,537)	(184,575)	78,062	59,889	(970)						(340,458)	45

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 378,000	Lansing Healthcare Properties	100.00%	$	$ (378,000)	1
2	V	33	Additional Rent - Prop	217,958	Lansing Healthcare Properties	100.00%	225,777	7,819	2
3	V	32	Interest	163,536	Lansing Healthcare Properties	100.00%	229,868	66,332	3
4	V	21	Bank Charges		Lansing Healthcare Properties	100.00%	365	365	4
5	V	30	Depreciation		Lansing Healthcare Properties	100.00%	76,346	76,346	5
6	V	17	Management Fees		Lansing Healthcare Properties	100.00%	1,050	1,050	6
7	V	19	Legal Fees		Lansing Healthcare Properties	100.00%	551	551	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 759,494			$ 533,957	$ * (225,537)	14

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 89	$ 89	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	398	398	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	298	298	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	672	672	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,773	2,773	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,843	1,843	20
21	V	19	Professional Fees	210,264	Extended Care Consulting, LLC	100.00%	5,256	(205,008)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	979	979	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,705	6,705	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	153	153	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	753	753	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	809	809	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,494	2,494	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	571	571	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,453	1,453	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	443	443	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			$ 210,264			$ 25,689	$ * (184,575)	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,779	$ 4,779	15
16	V	06	Maintenance (Direct)	25,669	Extended Care Consulting, LLC	100.00%	25,573	(96)	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	453	453	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	2,883	2,883	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,966	9,966	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	58,474	58,474	22
23	V	21	Office and Clerical (Direct)	18,115	Extended Care Consulting, LLC	100.00%	18,115		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	12,606	12,606	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,007	2,007	25
26	V	22	Employee Benefits	13,010	Extended Care Consulting, LLC	100.00%		(13,010)	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			$ 56,794			$ 134,856	$ * 78,062	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 56	$ 56	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	103	103	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	85	85	17
18	V	19	Professional Fees	70,092	Extended Care Clinical, LLC	100.00%	546	(69,546)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	146	146	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	843	843	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	766	766	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	305	305	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	720	720	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	20,410	20,410	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	274	274	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	2,742	2,742	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	313	313	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	25,265	25,265	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	11,445	11,445	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,191	4,191	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	39,979	39,979	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	15,463	15,463	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,329	6,329	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 70,092			$ 129,981	$ * 59,889	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	39	Various Equipment	10,895	Vent Lease LLC	100.00%	9,925	$ (970)	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			$ 10,895			$ 9,925	$ * (970)	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 135,290	$ 135,290	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	135,290	CCS Employee Benefits Group	100.00%		(135,290)	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			$ 135,290			$ 135,290	$ *	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1	Dietary Supplies, Supplements	$ 8,232	Care Centers Health Systems, Inc.	100.00%	$ 8,232	$	15
16	V	39	Ancillary Expense	3,480	Care Centers Health Systems, Inc.	100.00%	3,480		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			$ 11,712			$ 11,712	$ *	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$			$	$	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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$			$	$	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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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			$			$	$	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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES TRUST	4.7619%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LANSING HEALTHCARE PROPERTIES, LLC		BUILDING CO.	1
2	DANIEL ROTHNER TRUST	4.7619%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKKEEP	2
3	ERIC ROTHNER	1.1905%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	KATHRYN VALES TRUST	4.7619%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEM	4
5	KIMBERLY RICHMAN TRUST	4.7619%	GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	MELISSA ROTHNER TRUST	4.7619%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	VENT LEASE, LLC	EVANSTON	VENTILATOR RENTAL	6
7	NATHAN AND SHIRLEY ROTHNER	65.4762%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	7
8	RACHEL ROTHNER TRUST	4.7619%	MAJOR HOSPITAL DYER	DYER, IN	CARE CENTER BUILDING LLC	EVANSTON	BLDG COMPANY	8
9	WILLIAM ROTHNER TRUST	4.7619%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				22
23			WHEATON CARE CENTER	WHEATON				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Adam Vales	Relative	Clerical	N/A	See Attached	1.16	2.90%	Alloc Sal	$ 2,154	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.62	2.95%	Alloc Fee/Sal	5,877	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 8,031		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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 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 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	01	Dietary	Patient Days	1,251,572	31	$ 4,057	$	27,462	$ 89	1
2	02	Food	Patient Days	1,251,572	31	18,150		27,462	398	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		27,462	298	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		27,462	672	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		27,462	2,773	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		27,462	1,843	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		27,462	5,256	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		27,462	979	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		27,462	6,705	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		27,462	153	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		27,462	753	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		27,462	809	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		27,462	2,494	13
14	32	Interest	Patient Days	1,251,572	31	26,010		27,462	571	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		27,462	1,453	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		27,462	443	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 25,689	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 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 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	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	27,462	4,779	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		25,573	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		27,462	453	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			2,883	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	27,462	9,966	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	27,462	58,474	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		18,115	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		27,462	12,606	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			2,007	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					$ 4,662,721	$ 3,975,053		$ 134,856	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	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	03	Housekeeping	Patient Days	758,409	19	$ 1,549	$	27,462	$ 56	1
2	05	Utilities	Patient Days	758,409	19	2,849		27,462	103	2
3	06	Maintenance	Patient Days	758,409	19	2,348		27,462	85	3
4	19	Professional Fees	Patient Days	758,409	19	15,090		27,462	546	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042		27,462	146	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285		27,462	843	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158		27,462	766	7
8	26	Insurance	Patient Days	758,409	19	8,431		27,462	305	8
9	30	Depreciation	Patient Days	758,409	19	19,889		27,462	720	9
10	32	Interest	Patient Days	758,409	19	563,670		27,462	20,410	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558		27,462	274	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	27,462	2,742	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645		27,462	313	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	27,462	25,265	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	27,462	11,445	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731		27,462	4,191	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	27,462	39,979	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	27,462	15,463	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785		27,462	6,329	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,589,719	$ 2,620,691		$ 129,981	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	39	Various Equipment	Direct Allocation						9,925	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					$	$		$ 9,925	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 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	22	Employee Health Insurance	Direct Allocation			$	$		$ 135,290	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					$	$		$ 135,290	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 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 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	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 8,232	1
2	39	Ancillary Expense	Direct Allocation						3,480	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					$	$		$ 11,712	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 2,877,700			$ 164,036	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	Line of Credit							76	6
7	Lemont Property		X	Loan				1,082,177			65,833	7
8	See Supplemental Schedule							68,333			20,981	8
9	TOTAL Facility Related						$	$ 4,028,210			$ 250,925	9
	B. Non-Facility Related*											
10	Interest Income		X								(27,273)	10
11	Interest Income - Bldg Co		X								(163,536)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (190,809)	14
15	TOTALS (line 9+line14)						$	$ 4,028,210			$ 60,116	15

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Mattresses		X	Note payable			$	$ 52,471			$	8
9	Dell Computers		X	Note payable				15,862				9
10	Alloc from Extended Care Consulting		X								571	10
11	Alloc from Extended Care Clinical		X								20,410	11
12												12
13												13
14	TOTAL Working Capital							68,333			20,981	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 198,100	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.)		$ 204,682	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,582	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 213,103	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.)**		$ 2,750	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.		$ 222,435	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	281,966	8
	2010	190,035	9
	2011	176,370	10
	2012	188,666	11
	2013	202,955	12

2014 Accrual = $202,955 x 1.05 = $213103

Allocated from Extended Care Consulting LLC: $1,453

Allocated from Extended Care Clinical LLC: $274

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri State Nrsing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-30-305-035-0000	Long Term Care Property	$ 202,954.98	$ 202,954.98
2.	30-30-306-003-0000	Vacant Land	$ 7,819.35	$
3.	See Attached	Alloc from Extended Care Consult	$ 162,082.08	$ 1,644.90
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 372,856.41	$ 204,599.88

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri State Nrsing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,244 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 84,986	1
2	Allocated from Care Centers Building			8,322	2
3	TOTALS			$ 93,308	3

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	84		1995	1962	$ 2,932,035	$ 76,346	39	$ 146,602	$ 70,256	$ 2,834,304	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,177	1,177	23,493	9
10	Various			1996	82,791		20	4,140	4,140	77,529	10
11	Various			1997	44,854		20	2,243	2,243	39,285	11
12	Various			1998	47,497		20	2,271	2,271	40,434	12
13	Various			1999	39,389		20	1,969	1,969	30,966	13
14	Various			2000	13,995		20	700	700	10,116	14
15	Various			2001	20,621		20	1,031	1,031	14,110	15
16	Various			2002	8,353		20	107	107	7,505	16
17	Various			2003	20,578		20	896	896	17,112	17
18	Various			2004	61,438		20	3,714	3,714	60,603	18
19	Various			2005	140,855		20	13,971	13,971	125,446	19
20	Various			2006	29,295		20	2,398	2,398	22,859	20
21	Various			2007	49,428		20	1,795	1,795	45,268	21
22	Various			2008	83,465		20	5,277	5,277	66,100	22
23	Various			2009	28,775		20	2,878	2,878	14,282	23
24	Various			2010	11,849		20	911	911	3,913	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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Related Building Company (Pages 12F & 12G)		7,149			357	357	1,845	67
68	Related Party Allocations (Pages 12H & 12I)		36,367	2,299		2,299		25,165	68
69	Financial Statement Depreciation			72,456			(72,456)		69
70	TOTAL (lines 4 thru 69)		$ 3,683,165	$ 151,101		$ 194,734	$ 43,633	$ 3,460,335	70

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,683,165	$ 151,101		$ 194,734	$ 43,633	$ 3,460,335	1
2	Flooring	2011	30,564		20	3,056	3,056	11,462	2
3	New Hvac Unit	2011	20,366		20	2,037	2,037	7,468	3
4	Sprinkler System Repair	2011	6,584		20	658	658	2,140	4
5	Roof	2011	54,600		20	5,460	5,460	17,290	5
6	Wall Guards	2011	4,995		20	999	999	3,996	6
7	Painting	2011	47,763		20	2,388	2,388	7,364	7
8	Sewer Piping	2012	7,000		20	700	700	1,983	8
9	Sewer Piping	2012	3,883		20	388	388	1,100	9
10	Signage	2012	3,200		20	320	320	880	10
11	Vinyl Flooring	2012	5,797		20	1,159	1,159	3,092	11
12	62 New Replacement Windows	2013	32,250		20	3,225	3,225	5,644	12
13	Remove & Install New Condensing Unit	2013	26,500		20	2,650	2,650	4,638	13
14	Walk-In Freezer - Kitchen	2013	7,296		20	1,459	1,459	2,432	14
15	3 Additional Replacement Windows	2013	4,180		20	418	418	662	15
16	New Fence	2013	3,275		20	328	328	519	16
17	Removed Asphalt, Restriped Parking Lot	2013	98,256		20	4,097	4,097	7,369	17
18	American Standard Hvac Unit	2013	7,100		20	710	710	769	18
19	South Wing Hvac System Replacement	2014	36,749		20	1,072	1,072	1,072	19
20	40 Yellow And 3 Blue Parking Bumpers	2014	4,702		20	104	104	104	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)		$ 4,088,225	$ 151,101		$ 225,963	$ 74,862	$ 3,540,317	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,088,225	$ 151,101		$ 225,963	$ 74,862	$ 3,540,317	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)		$ 4,088,225	$ 151,101		$ 225,963	$ 74,862	$ 3,540,317	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,088,225	$ 151,101		$ 225,963	$ 74,862	$ 3,540,317	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)		$ 4,088,225	$ 151,101		$ 225,963	$ 74,862	$ 3,540,317	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,088,225	$ 151,101		$ 225,963	$ 74,862	$ 3,540,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		$ 4,088,225	$ 151,101		$ 225,963	$ 74,862	$ 3,540,317	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Heating Repairs	2008	7,149		20	357	357	1,845	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)		$ 7,149	$		$ 357	$ 357	$ 1,845	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 7,149	$		$ 357	$ 357	$ 1,845	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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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)		$ 7,149	$		$ 357	$ 357	$ 1,845	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Care Centers Building LLC	2002	9,651	247	20	247		3,042	3
4	Allocated from Care Centers Building LLC	2002	1,817	47	20	47		573	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting LLC	2007	101	5	20	5		40	9
10	Allocated from Extended Care Consulting LLC	2009	60	3	20	3		18	10
11	Allocated from Extended Care Consulting LLC	2010	592	30	20	30		148	11
12	Allocated from Extended Care Consulting LLC	2011	213	11	20	11		43	12
13	Allocated from Extended Care Consulting LLC	2012	70	4	20	4		11	13
14	Allocated from Extended Care Consulting LLC	2014	973	49	20	49		49	14
15									15
16	Allocated from Care Centers Building LLC	2002	7,972	679	20	679		7,972	16
17	Allocated from Care Centers Building LLC	2003	9,395	801	20	801		9,395	17
18	Allocated from Care Centers Building LLC	2005	467	50	20	50		416	18
19	Allocated from Care Centers Building LLC	2009	84	4	20	4		25	19
20	Allocated from Care Centers Building LLC	2014	1,345	67	20	67		67	20
21									21
22	Allocated from Care Centers Building LLC	2002	1,501	128	20	128		1,501	22
23	Allocated from Care Centers Building LLC	2003	1,769	151	20	151		1,769	23
24	Allocated from Care Centers Building LLC	2005	88	9	20	9		78	24
25	Allocated from Care Centers Building LLC	2009	16	1	20	1		5	25
26	Allocated from Care Centers Building LLC	2014	253	13	20	13		13	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 36,367	$ 2,299		$ 2,299	$	$ 25,165	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 36,367	$ 2,299		$ 2,299	$	$ 25,165	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)		$ 36,367	$ 2,299		$ 2,299	$	$ 25,165	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 144,017	$ 270	$ 10,304	$ 10,034	10	$ 114,098	71
72	Current Year Purchases	103,797	162	2,055	1,893	10	2,055	72
73	Fully Depreciated Assets	432,697				10	432,697	73
74								74
75	TOTALS	$ 680,511	$ 432	$ 12,358	$ 11,926		$ 548,849	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		BUS	1997	$ 47,208	$	$	$	5	$ 35,408	76
77		Allocated from Extended Care C	2014	3,960	112	112		5	3,512	77
78		Allocated from Extended Care C	2014	1,860	372	372		5	922	78
79										79
80	TOTALS			$ 53,028	$ 484	$ 484	$		$ 39,842	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)	$ 4,915,072	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 152,017	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 238,806	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 86,788	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,129,008	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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 11,526 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 292,990	$		$ 292,990	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			202,397			202,397	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			315,533			315,533	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				200,839		200,839	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					11,547	93,647		105,194	13
14	TOTAL			$		$ 822,467	$ 294,486		$ 1,116,953	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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 134,137	$ 305,627	1
2	Cash-Patient Deposits	29,451	29,451	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	250,547	250,547	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	145,381	145,381	6
7	Other Prepaid Expenses	4,509	4,509	7
8	Accounts Receivable (owners or related parties)	421,185	4,386,862	8
9	Other(specify):	282,607	282,607	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,267,817	$ 5,404,984	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	1,046,884	1,046,884	15
16	Equipment, at Historical Cost	463,045	633,018	16
17	Accumulated Depreciation (book methods)	(1,123,488)	(2,761,931)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 386,441	$ 2,010,511	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,654,258	$ 7,415,495	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,296,546	$ 1,296,545	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,722	20,722	28
29	Short-Term Notes Payable	68,333	68,333	29
30	Accrued Salaries Payable	193,815	193,815	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,714	10,714	31
32	Accrued Real Estate Taxes(Sch.IX-B)	213,103	213,103	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	490,559	489,809	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,293,792	$ 2,293,041	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,082,177	39
40	Mortgage Payable		2,877,700	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)**	$	$ 3,959,877	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,293,792	$ 6,252,918	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (639,534)	$ 1,162,577	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,654,258	$ 7,415,495	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (680,105)	1
2	Restatements (describe):		2
3	**Prior Year Bad Debt Adjustment**	(33,079)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (713,184)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,650	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)**	$ 73,650	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)**	$ (639,534)	24 *

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 6,421,098	1
2	Discounts and Allowances for all Levels	(2,535,654)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,885,444	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,744,629	6
7	Oxygen	13,808	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,758,437	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	207,298	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,962	19
20	Radiology and X-Ray	6,055	20
21	Other Medical Services	37,668	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 263,983	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,273	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,273	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,642	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,642	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,936,779	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	994,302	31
32	Health Care	2,349,858	32
33	General Administration	1,534,735	33
	B. Capital Expense		
34	Ownership	679,574	34
	C. Ancillary Expense		
35	Special Cost Centers	1,116,953	35
36	Provider Participation Fee	187,707	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,863,129	40
41	**Income before Income Taxes (line 30 minus line 40)****	73,650	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 73,650	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,380,078	44
45	Private Pay - Net Inpatient Revenue	349,862	45
46	Medicare - Net Inpatient Revenue	(63,467)	46
47	Other-(specify) Hospice	204,925	47
48	Other-(specify) Insurance	14,046	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,885,444	49

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

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

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

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

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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	2,006	2,030	$ 92,376	$ 45.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,992	14,597	422,443	28.94	3
4	Licensed Practical Nurses	18,572	20,092	547,543	27.25	4
5	CNAs & Orderlies	45,618	50,974	540,439	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,981	10,136	172,781	17.05	8
9	Activity Director	1,667	1,798	29,864	16.61	9
10	Activity Assistants	7,071	7,780	73,078	9.39	10
11	Social Service Workers	6,466	7,002	185,023	26.42	11
12	Dietician					12
13	Food Service Supervisor	1,915	2,074	48,000	23.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,212	5,910	71,861	12.16	15
16	Dishwashers	8,794	9,501	112,961	11.89	16
17	Maintenance Workers	3,338	3,457	68,765	19.89	17
18	Housekeepers	9,460	10,654	110,479	10.37	18
19	Laundry	3,946	4,668	62,029	13.29	19
20	Administrator	1,972	2,238	95,239	42.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,207	6,645	94,533	14.23	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	1,784	1,824	28,723	15.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental S	1,841	1,887	34,612	18.34	33
34	TOTAL (lines 1 - 33)	147,842	163,267	$ 2,790,749 *	$ 17.09	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	282	$ 15,031	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,715	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Per Visit	82	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	$ 38,828		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Elkaim	Administrator	0	$ 86,452
Sarah Simons	Administrator	0	8,787
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,239

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 25,750
See Attached	Legal	21,443
Extended Care Consulting LLC	Home Office Expense	210,264
Extended Care Clinical LLC	Home Office Expense	70,092
Personnel Planners	Unemployment Consultant	2,155
Pro Payroll Solutions	Payroll Services	16,392
E-Health Data Solutions	MDS Software Fee	2,385
AIS Assessment & Intelligence	MDS Consulting	1,329
Ability Network	Medicare Billing	1,450
National Datacare Corporation	Resident Fund Processing	1,467
Data P/Ability Network	Computer Services	404
See Supplemental Schedule		21,215
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 374,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,706
Unemployment Compensation Insurance	92,802
FICA Taxes	209,847
Employee Health Insurance	156,619
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,758
Pension Exp	17,067
Other Employee Welfare	10,190
Holiday Expense	1,091
TOTAL (agree to Schedule V, line 22, col.8)	$ 600,079

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	10,405
Health Care Worker Background Check	
(Indicate # of checks performed 133)	1,726
Patient Background Checks	
Dues and Subscriptions	9,144
License and Permits	3,744
Alloc from Extended Care Consulting	979
Alloc from Extended Care Clinical	146
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,135

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,036
Alloc from Extended Care Consulting	153
Alloc from Extended Care Clinical	766
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,955

**See instructions.

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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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
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10													
11													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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. **IL Council on Long Term Care $7,854**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,951** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **187,707**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% 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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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