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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0041186

Facility Name: Tri-State Nsg & Rehab Ctr

Address: 2500 E. 175Th Street (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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	21,035	1,783	4,172	26,990	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,035	1,783	4,172	26,990	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.03%

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 4,138

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	234,534	45,961	11,322	291,817		291,817	5,037	296,854			1
2	Food Purchase		159,792		159,792		159,792	134	159,926			2
3	Housekeeping	109,661	23,686		133,347		133,347	694	134,041			3
4	Laundry	73,396	10,158		83,554		83,554		83,554			4
5	Heat and Other Utilities			78,662	78,662		78,662	1,044	79,706			5
6	Maintenance	58,662		108,133	166,795		166,795	(52,539)	114,256			6
7	Other (specify):*							1,709	1,709			7
8	**TOTAL General Services**	476,253	239,597	198,117	913,967		913,967	(43,921)	870,046			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,691,298	155,301	79,983	1,926,582		1,926,582	23,548	1,950,130			10
10a	Therapy	144,063		595	144,658		144,658		144,658			10a
11	Activities	111,865	21,496		133,361		133,361		133,361			11
12	Social Services	134,289	70		134,359		134,359	14,117	148,476			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,841	4,841			15
16	**TOTAL Health Care and Programs**	2,081,515	176,867	98,578	2,356,960		2,356,960	42,506	2,399,466			16
	C. General Administration											
17	Administrative	80,067			80,067		80,067	49,597	129,664			17
18	Directors Fees											18
19	Professional Services			395,965	395,965	(9,180)	386,785	(300,276)	86,509			19
20	Dues, Fees, Subscriptions & Promotions			64,579	64,579		64,579	(26,010)	38,569			20
21	Clerical & General Office Expenses	92,078	28,140	364,457	484,675		484,675	(231,944)	252,731			21
22	Employee Benefits & Payroll Taxes			558,948	558,948		558,948	(6,330)	552,618			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,042	2,042		2,042	824	2,866			24
25	Other Admin. Staff Transportation			4,039	4,039		4,039	767	4,806			25
26	Insurance-Prop.Liab.Malpractice			100,273	100,273		100,273	1,088	101,361			26
27	Other (specify):*							19,180	19,180			27
28	**TOTAL General Administration**	172,145	28,140	1,490,303	1,690,588	(9,180)	1,681,408	(493,104)	1,188,304			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,729,913	444,604	1,786,998	4,961,515	(9,180)	4,952,335	(494,519)	4,457,816			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 Nsg & Rehab Ctr #0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			72,751	72,751		72,751	134,453	207,204			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			368	368		368	65,416	65,784			32
33	Real Estate Taxes			306,551	306,551	9,180	315,731	2,758	318,489			33
34	Rent-Facility & Grounds			378,000	378,000		378,000	(378,000)				34
35	Rent-Equipment & Vehicles			4,099	4,099		4,099	457	4,556			35
36	Other (specify):*											36
37	**TOTAL Ownership**			761,769	761,769	9,180	770,949	(174,916)	596,033			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		327,024	678,913	1,005,937		1,005,937	(890)	1,005,047			39
40	Barber and Beauty Shops			30	30		30		30			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			184,100	184,100		184,100		184,100			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		327,024	863,043	1,190,067		1,190,067	(890)	1,189,177			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,729,913	771,628	3,411,810	6,913,351		6,913,351	(670,325)	6,243,026			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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	25,016	30		9
10	Interest and Other Investment Income	(5,519)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(104)	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	(2,530)	21		18
19	Entertainment				19
20	Contributions	(467)	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	(297,466)	21		24
25	Fund Raising, Advertising and Promotional	(19,078)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(60,839)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (360,988)		$	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)	(309,337)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (309,337)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (670,325)		37

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

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

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

Tri-State Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (900)	21	1
2	Patient Clothing	(340)	10	2
3	Charitable Donations	(1,000)	20	3
4	Theft Loss	(351)	21	4
5	Collection Expense	(6,910)	21	5
6	Building Company - Management Fees	(4,200)	17	6
7	Building Company - Bank Charges	(472)	21	7
8	Capitalized R&M	(17,254)	06	8
9	Annual Report	(250)	20	9
10	PAC Dues	(5,716)	20	10
11	Lansing Chamber of Commerce Dues	(160)	20	11
12	Non Allowable Legal	(23,287)	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**	(60,839)		49

Tri-State Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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		4,948							5,037	1
2	Food Purchase	(104)		238									134	2
3	Housekeeping			627		67							694	3
4	Laundry													4
5	Heat and Other Utilities			951		93							1,044	5
6	Maintenance	(17,254)	(43,546)	2,736	5,455	70							(52,539)	6
7	Other (specify):*				1,084	625							1,709	7
8	**TOTAL General Services**	(17,358)	(43,546)	4,641	6,539	5,803							(43,921)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(340)				24,197			(309)				23,548	10
10a	Therapy													10a
11	Activities													11
12	Social Services					14,117							14,117	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,841							4,841	15
16	**TOTAL Health Care and Programs**	(340)				43,155			(309)				42,506	16
	C. General Administration													
17	Administrative	(4,200)	4,200	1,710	9,566	38,321							49,597	17
18	Directors Fees													18
19	Professional Services	(23,287)		(207,243)		(69,746)							(300,276)	19
20	Fees, Subscriptions & Promotions	(26,671)		560		101							(26,010)	20
21	Clerical & General Office Expenses	(308,629)	472	6,998	57,292	11,923							(231,944)	21
22	Employee Benefits & Payroll Taxes				(6,330)			(0)					(6,330)	22
23	Inservice Training & Education													23
24	Travel and Seminar			192		632							824	24
25	Other Admin. Staff Transportation			767									767	25
26	Insurance-Prop.Liab.Malpractice			782		306							1,088	26
27	Other (specify):*				12,940	6,240							19,180	27
28	**TOTAL General Administration**	(362,787)	4,672	(196,234)	73,468	(12,223)		(0)					(493,104)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(380,485)	(38,874)	(191,593)	80,007	36,735		(0)	(309)				(494,519)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Tri-State Nsg & Rehab Ctr** **#** **0041186** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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	25,016	107,786	1,240		411							134,453	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,519)	65,832	4,986		117							65,416	32
33	Real Estate Taxes			2,499		259							2,758	33
34	Rent-Facility & Grounds		(378,000)										(378,000)	34
35	Rent-Equipment & Vehicles			457									457	35
36	Other (specify):*													36
37	**TOTAL Ownership**	19,497	(204,382)	9,182		787							(174,916)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(890)				(890)	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**								(890)				(890)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(360,988)	(243,256)	(182,411)	80,007	37,522		(0)	(1,199)				(670,325)	45

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	306,551	Lansing Healthcare Properties	100.00%	306,551		2
3	V	06	Sign	43,546	Lansing Healthcare Properties	100.00%		(43,546)	3
4	V	32	Interest	155,785	Lansing Healthcare Properties	100.00%	221,617	65,832	4
5	V	21	Bank Charges		Lansing Healthcare Properties	100.00%	472	472	5
6	V	30	Depreciation		Lansing Healthcare Properties	100.00%	107,786	107,786	6
7	V	17	Management Fees		Lansing Healthcare Properties	100.00%	4,200	4,200	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 883,882			$ 640,626	$ * (243,256)	14

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	238	238	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	627	627	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	951	951	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,736	2,736	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,710	1,710	20
21	V	19	Professional Fees	210,264	Extended Care Consulting, LLC	100.00%	3,021	(207,243)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	560	560	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,998	6,998	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	192	192	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	767	767	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	782	782	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,240	1,240	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,986	4,986	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,499	2,499	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	457	457	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			$ 27,853	$ * (182,411)	39

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	5,455	$ 5,455	15
16	V	06	Maintenance (Direct)	4,663	Extended Care Consulting, LLC	100.00%	4,663		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	469	469	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	615	615	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,566	9,566	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	57,292	57,292	22
23	V	21	Office and Clerical (Direct)	16,436	Extended Care Consulting, LLC	100.00%	16,436		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	11,477	11,477	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,463	1,463	25
26	V	22	Employee Benefits	6,330	Extended Care Consulting, LLC	100.00%		(6,330)	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			$ 27,429			$ 107,436	$ * 80,007	39

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 67	$ 67	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	93	93	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	70	70	17
18	V	19	Professional Fees	70,092	Extended Care Clinical, LLC	100.00%	346	(69,746)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	101	101	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	857	857	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	632	632	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	306	306	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	411	411	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	117	117	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	259	259	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	4,948	4,948	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	625	625	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	24,197	24,197	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	14,117	14,117	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,841	4,841	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	38,321	38,321	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	11,066	11,066	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,240	6,240	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 70,092			$ 107,614	$ * 37,522	39

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	9,320	Vent Lease LLC	100.00%	9,320	$	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			$ 9,320			$ 9,320	$ *	39

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 115,882	$ 115,882	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	115,882	CCS Employee Benefits Group	100.00%		(115,882)	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			$ 115,882			$ 115,882	$ * (0)	39

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 23,413	MAC Rx, LLC	100.00%	$ 23,104	$ (309)	15
16	V	39	Ancillary	67,393	MAC Rx, LLC	100.00%	66,503	(890)	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			$ 90,806			$ 89,607	$ * (1,199)	39

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	ERIC ROTHNER	1.1905%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	KATHRYN VALES TRUST	4.7619%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING CO.	4
5	KIMBERLY RICHMAN TRUST	4.7619%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQIP	5
6	MELISSA ROTHNER TRUST	4.7619%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	TRI CARE REHAB	HILLSIDE	THERAPY	6
7	NATHAN AND SHIRLEY ROTHNER	65.4762%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8	RACHEL ROTHNER TRUST	4.7619%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	8
9	WILLIAM ROTHNER TRUST	4.7619%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	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			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Adam Vales	Relative	Clerical	N/A	See Attached	0.73	1.83%	Alloc Sal	$ 1,243	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.55	2.82%	Alloc Fee/Sal	5,754	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	$ 6,997		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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	26,990	$ 89	1
2	02	Food	Patient Days	1,326,152	31	11,689		26,990	238	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		26,990	627	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		26,990	951	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		26,990	2,736	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		26,990	1,710	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		26,990	3,021	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		26,990	560	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		26,990	6,998	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		26,990	192	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		26,990	767	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		26,990	782	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		26,990	1,240	13
14	32	Interest	Patient Days	1,326,152	31	244,990		26,990	4,986	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		26,990	2,499	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		26,990	457	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 27,853	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	26,990	5,455	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		4,663	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		26,990	469	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			615	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	26,990	9,566	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	26,990	57,292	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		16,436	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		26,990	11,477	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			1,463	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					$ 4,964,932	$ 4,280,758		$ 107,436	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	794,254	19	$ 1,974	$	26,990	$ 67	1
2	05	Utilities	Patient Days	794,254	19	2,745		26,990	93	2
3	06	Maintenance	Patient Days	794,254	19	2,053		26,990	70	3
4	19	Professional Fees	Patient Days	794,254	19	10,180		26,990	346	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961		26,990	101	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207		26,990	857	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605		26,990	632	7
8	26	Insurance	Patient Days	794,254	19	9,008		26,990	306	8
9	30	Depreciation	Patient Days	794,254	19	12,096		26,990	411	9
10	32	Interest	Patient Days	794,254	19	3,455		26,990	117	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615		26,990	259	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	145,601	26,990	4,948	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397		26,990	625	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	712,051	26,990	24,197	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	415,434	26,990	14,117	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463		26,990	4,841	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	1,127,702	26,990	38,321	17
18	21	Office Salary	Patient Days	794,254	19	325,657	325,657	26,990	11,066	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638		26,990	6,240	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,166,842	$ 2,726,445		$ 107,614	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						9,320	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					$	$		$ 9,320	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 115,882	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					$	$		$ 115,882	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 23,104	1
2	39	Ancillary	Direct Allocation						66,503	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					$	$		$ 89,607	25

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$ 2,737,300			$ 155,785	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	Line of Credit							368	6
7	Lemont Property		X	Loan				1,082,177			65,832	7
8	See Supplemental Schedule							26,149			5,103	8
9	TOTAL Facility Related						$	$ 3,845,626			$ 227,088	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,519)	10
11	Interest Income - Bldg Co		X								(155,785)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (161,304)	14
15	TOTALS (line 9+line14)						$	$ 3,845,626			$ 65,784	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$ 26,149			$	8
9	Alloc from Extended Care Consulting		X								4,986	9
10	Alloc from Extended Care Clinical		X								117	10
11												11
12												12
13												13
14	TOTAL Working Capital							26,149			5,103	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 Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 221,804	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.)		$ 264,949	2
3. Under or (over) accrual (line 2 minus line 1).		$ 43,145	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 266,164	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.**		$ 9,180	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.		$ 318,489	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	190,035	8
	2011	176,370	9
	2012	188,666	10
	2013	202,955	11
	2014	262,191	12

2015 Accrual = $262,191 x 1.015 = $266,125 (Rounded)
Allocated from Extended Care Consulting LLC: $2,499
Allocated from Extended Care Clinical LLC: $259
***Beginning Accrual Adjusted For Previously Vacant Land**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nsg & 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 2014 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 2014.

	(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	$ 253,489.99	$ 253,489.99
2.	30-30-306-003-0000	Long Term Care Property	$ 8,701.25	$ 8,701.25
3.	See Attached	Allocated from 2201 W. Main	$ 165,913.23	$ 2,615.72
4.	See Attached	Allocated from 502 Main Street	$ 3,814.66	$ 77.64
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 431,919.13	$ 264,884.60

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Nsg & 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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 2201 W. Main, LLC / Clinical			12,928	2
3	TOTALS			$ 97,914	3

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 107,786	39	$ 97,731	$ (10,055)	$ 2,932,035	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	933	933	24,426	9
10	Various			1996	82,791		20	4,097	4,097	81,626	10
11	Various			1997	44,854		20	2,243	2,243	41,528	11
12	Various			1998	47,497		20	2,271	2,271	42,705	12
13	Various			1999	39,389		20	1,969	1,969	32,935	13
14	Various			2000	13,995		20	700	700	10,816	14
15	Various			2001	20,621		20	1,031	1,031	15,141	15
16	Various			2002	8,353		20	107	107	7,612	16
17	Various			2003	20,578		20	540	540	17,653	17
18	Various			2004	61,438		20	87	87	60,691	18
19	Various			2005	140,855		20	10,613	10,613	136,059	19
20	Various			2006	29,295		20	2,398	2,398	25,257	20
21	Various			2007	49,428		20	1,625	1,625	46,894	21
22	Various			2008	83,465		20	4,801	4,801	70,900	22
23	Various			2009	28,775		20	2,878	2,878	17,160	23
24	Various			2010	11,849		20	911	911	4,824	24
25	Various			2011	164,873		20	14,599	14,599	64,317	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,202	67
68	Related Party Allocations (Pages 12H & 12I)		54,447	734		734		39,580	68
69	Financial Statement Depreciation			72,751			(72,751)		69
70	TOTAL (lines 4 thru 69)		$ 3,866,118	$ 181,271		$ 150,625	$ (30,646)	$ 3,674,360	70

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,866,118	$ 181,271		$ 150,625	$ (30,646)	$ 3,674,360	1
2	Sewer Piping	2012	7,000		20	700	700	2,683	2
3	Sewer Piping	2012	3,883		20	388	388	1,488	3
4	Signage	2012	3,200		20	320	320	1,200	4
5	Vinyl Flooring	2012	5,797		20	1,159	1,159	4,251	5
6	62 New Replacement Windows	2013	32,250		20	3,225	3,225	8,869	6
7	Remove & Install New Condensing Unit	2013	26,500		20	2,650	2,650	7,288	7
8	Walk-In Freezer - Kitchen	2013	7,296		20	1,459	1,459	3,891	8
9	3 Additional Replacement Windows	2013	4,180		20	418	418	1,080	9
10	New Fence	2013	3,275		20	328	328	846	10
11	Removed Asphalt, Restriped Parking Lot	2013	98,256		20	6,554	6,554	13,923	11
12	American Standard Hvac Unit	2013	7,100		20	710	710	1,479	12
13	South Wing Hvac System Replacement	2014	36,749		20	1,837	1,837	2,909	13
14	40 Yellow And 3 Blue Parking Bumpers	2014	4,702		20	313	313	418	14
15	Door System - Double Door, Installation Of Door Wander Control	2015	13,512		20	2,477	2,477	2,477	15
16	Replace Roof Over Boiler Room/Roof Repairs/16 Sheets Of Plywo	2015	9,000		20	450	450	450	16
17	Replace Bad Condenser - Rewire Power And Control To Unit	2015	2,599		20	128	128	128	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)		$ 4,131,416	$ 181,271		$ 173,742	$ (7,529)	$ 3,727,741	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 4,131,416	$ 181,271		$ 173,742	$ (7,529)	$ 3,727,741	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)		$ 4,131,416	$ 181,271		$ 173,742	$ (7,529)	$ 3,727,741	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 4,131,416	$ 181,271		$ 173,742	$ (7,529)	$ 3,727,741	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)		$ 4,131,416	$ 181,271		$ 173,742	$ (7,529)	$ 3,727,741	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 4,131,416	$ 181,271		$ 173,742	$ (7,529)	$ 3,727,741	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)		$ 4,131,416	$ 181,271		$ 173,742	$ (7,529)	$ 3,727,741	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Building Company		$	$		$	$	$	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	2,202	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	$ 2,202	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 2,202	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,149	$		$ 357	$ 357	$ 2,202	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 W. Main, LLC	2002	16,095	413	39	413		5,485	3
4									4
5	Allocated from Extended Care Clinical, LLC	2002	1,721	44	39	44		586	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	94	5	20	5		42	9
10	Allocated from Extended Care Consulting, LLC	2009	56	3	20	3		20	10
11	Allocated from Extended Care Consulting, LLC	2010	549	27	20	27		165	11
12	Allocated from Extended Care Consulting, LLC	2011	198	10	20	10		49	12
13	Allocated from Extended Care Consulting, LLC	2012	65	3	20	3		13	13
14	Allocated from Extended Care Consulting, LLC	2014	903	45	20	45		90	14
15									15
16									16
17	Allocated from 2201 W. Main, LLC	2002	13,295		20			13,295	17
18	Allocated from 2201 W. Main, LLC	2003	15,668		20			15,668	18
19	Allocated from 2201 W. Main, LLC	2005	778	83	20	83		777	19
20	Allocated from 2201 W. Main, LLC	2009	140	7	20	7		49	20
21	Allocated from 2201 W. Main, LLC	2014	1,306	65	20	65		131	21
22	Allocated from 2201 W. Main, LLC	2015	221	11	20	11		11	22
23									23
24	Allocated from Extended Care Clinical, LLC	2002	1,421		20			1,421	24
25	Allocated from Extended Care Clinical, LLC	2003	1,675		20			1,675	25
26	Allocated from Extended Care Clinical, LLC	2005	83	9	20	9		83	26
27	Allocated from Extended Care Clinical, LLC	2009	15	1	20	1		5	27
28	Allocated from Extended Care Clinical, LLC	2014	140	7	20	7		14	28
29	Allocated from Extended Care Clinical, LLC	2015	24	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 54,447	$ 734		$ 734	$	$ 39,580	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 54,447	$ 734		$ 734	$	$ 39,580	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)		$ 54,447	$ 734		$ 734	$	$ 39,580	34

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 238,410	$ 401	$ 29,895	$ 29,494	10	$ 136,843	71
72	Current Year Purchases	17,782	63	3,114	3,051	10	3,114	72
73	Fully Depreciated Assets	439,040				10	439,040	73
74								74
75	TOTALS	$ 695,231	$ 464	$ 33,009	$ 32,545		$ 578,997	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 EC Consulting, LL	2015	3,673	104	104		5	3,362	77
78		Allocated from EC Clinical, LLC	2012	1,746	349	349		5	1,214	78
79										79
80	TOTALS			$ 52,627	$ 453	$ 453	$		$ 39,984	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)	$ 4,977,188	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,188	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 207,204	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,016	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,346,722	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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,556 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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$		$ 242,210	$		$ 242,210	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			165,676			165,676	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			261,707			261,707	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				184,191		184,191	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					9,320	142,833		152,153	13
14	TOTAL			$		$ 678,913	$ 327,024		$ 1,005,937	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 Nsg & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 3,587	$ 411,156	1
2	Cash-Patient Deposits	27,053	27,053	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	27,539	27,539	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	174,474	174,474	6
7	Other Prepaid Expenses	120,601	120,601	7
8	Accounts Receivable (owners or related parties)	365,835	3,791,615	8
9	Other(specify):	790,016	827,495	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,509,105	$ 5,379,933	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	488,057	658,030	16
17	Accumulated Depreciation (book methods)	(1,196,239)	(3,548,982)	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)**	$ 338,702	$ 1,248,472	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,847,807	$ 6,628,405	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,299,275	$ 1,299,274	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,666	21,666	28
29	Short-Term Notes Payable	26,149	26,149	29
30	Accrued Salaries Payable	198,304	198,304	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,846	15,846	31
32	Accrued Real Estate Taxes(Sch.IX-B)	266,164	266,164	32
33	Accrued Interest Payable		12,964	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	418,221	418,221	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,245,625	$ 2,258,588	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,082,177	39
40	Mortgage Payable		2,737,300	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	489,943		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 489,943	$ 3,819,477	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,735,568	$ 6,078,065	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (887,761)	$ 550,340	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,847,807	$ 6,628,405	48

***(See instructions.)**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (639,534)	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (639,533)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(248,228)	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)**	$ (248,228)	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)**	$ (887,761)	24 *

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

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 6,325,733	1
2	Discounts and Allowances for all Levels	(2,464,291)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,861,442	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,497,741	6
7	Oxygen	6,939	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,504,680	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	197,925	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,414	19
20	Radiology and X-Ray	7,212	20
21	Other Medical Services	74,031	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 292,582	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,519	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,519	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	900	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 900	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,665,123	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	913,967	31
32	Health Care	2,356,960	32
33	General Administration	1,690,588	33
	B. Capital Expense		
34	Ownership	761,769	34
	C. Ancillary Expense		
35	Special Cost Centers	1,005,967	35
36	Provider Participation Fee	184,100	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,913,351	40
41	**Income before Income Taxes (line 30 minus line 40)****	(248,228)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (248,228)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,414,803	44
45	Private Pay - Net Inpatient Revenue	351,083	45
46	Medicare - Net Inpatient Revenue	(15,602)	46
47	Other-(specify) Hospice	104,522	47
48	Other-(specify) Insurance	6,636	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,861,442	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.**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,055	2,079	$ 96,867	$ 46.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,929	11,274	343,927	30.51	3
4	Licensed Practical Nurses	20,186	22,272	634,277	28.48	4
5	CNAs & Orderlies	44,500	51,320	543,604	10.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,154	8,045	144,063	17.91	8
9	Activity Director	2,051	2,121	36,449	17.18	9
10	Activity Assistants	7,404	8,700	75,416	8.67	10
11	Social Service Workers	5,625	6,056	134,289	22.17	11
12	Dietician					12
13	Food Service Supervisor	1,917	2,096	50,204	23.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,344	6,283	71,503	11.38	15
16	Dishwashers	8,976	10,261	112,827	11.00	16
17	Maintenance Workers	2,035	2,278	58,662	25.75	17
18	Housekeepers	9,880	11,242	109,661	9.75	18
19	Laundry	4,299	5,482	73,396	13.39	19
20	Administrator	2,057	2,203	80,067	36.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,076	6,544	92,078	14.07	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	1,952	1,972	34,174	17.33	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,065	2,159	38,449	17.81	33
34	TOTAL (lines 1 - 33)	143,505	162,387	$ 2,729,913 *	$ 16.81	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	223	$ 11,322	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	5,554	10-03	39
40	Physical Therapy Consultant	Per Visit	79	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7	516	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	230	$ 35,471		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	153	$ 7,656	10-03	50
51	Licensed Practical Nurses	408	16,314	10-03	51
52	Certified Nurse Assistants/Aides	2,018	50,459	10-03	52
53	TOTAL (lines 50 - 52)	2,579	$ 74,429		53

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sarah Simons	Administrator	0	$ 80,067
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,067

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
See Attached	Legal	$ 51,487
Frost / Marcum	Accounting	27,889
Personnel Planners	Unemployment Consultant	2,149
Extended Care Consulting LLC	Home Office Expense	210,264
Extended Care Clinical LLC	Home Office Expense	70,092
The William Everett Group	IT Consulting	160
Hamlin and Burton Liability	Liability Insurance Services	548
DAIWA	Line of Credit Audit	4,621
Legat Architects	Architectural Services	2,495
Pinnacle Quality Insight	Customer Satisfaction	2,660
Pro Payroll Solutions	Payroll Services	16,074
See Supplemental Schedule		7,526
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 395,965

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,715
Unemployment Compensation Insurance	82,810
FICA Taxes	208,838
Employee Health Insurance	130,794
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	6,227
Pension Exp	20,834
Other Employee Welfare	9,312
Holiday Expense	1,087
TOTAL (agree to Schedule V, line 22, col.8)	$ 552,617

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	9,190
Health Care Worker Background Check	4,649
(Indicate # of checks performed 124)	
Patient Background Checks	
Dues and Subscriptions	17,873
License and Permits	4,207
Alloc from Extended Care Consulting	560
Alloc from Extended Care Clinical	101
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,571

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,042
Alloc from Extended Care Consulting	192
Alloc from Extended Care Clinical	632
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,866

**See instructions.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/15 Ending: 12/31/15

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													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Tri-State Nsg & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 $17,320**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,628** 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. $ **184,100**
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.