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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0041186

Facility Name: Tri State Nrsing & Rehab Ctr

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 9/1/1995

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	20,496	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,248	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,744	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	21,039	2,559	4,011	27,609	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,039	2,559	4,011	27,609	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.80%

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 3,243

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	231,739	51,853	10,880	294,472		294,472	5,537	300,009			1
2	Food Purchase		159,681		159,681		159,681	69	159,750			2
3	Housekeeping	107,215	23,003		130,218		130,218	638	130,856			3
4	Laundry	70,719	12,984		83,703		83,703		83,703			4
5	Heat and Other Utilities			73,754	73,754		73,754	882	74,636			5
6	Maintenance	59,767		105,608	165,375		165,375	(1,569)	163,806			6
7	Other (specify):*							1,468	1,468			7
8	**TOTAL General Services**	469,440	247,521	190,242	907,203		907,203	7,025	914,228			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,629,618	161,295	60,484	1,851,397		1,851,397	21,029	1,872,426			10
10a	Therapy	192,166		484	192,650		192,650		192,650			10a
11	Activities	101,605	24,843		126,448		126,448		126,448			11
12	Social Services	143,976			143,976		143,976	13,156	157,132			12
13	CNA Training											13
14	Program Transportation			1,348	1,348		1,348		1,348			14
15	Other (specify):*							4,940	4,940			15
16	**TOTAL Health Care and Programs**	2,067,365	186,138	80,316	2,333,819		2,333,819	39,125	2,372,944			16
	C. General Administration											
17	Administrative	80,815			80,815		80,815	55,262	136,077			17
18	Directors Fees											18
19	Professional Services			475,231	475,231	(3,321)	471,910	(320,677)	151,233			19
20	Dues, Fees, Subscriptions & Promotions			51,094	51,094		51,094	(18,650)	32,445			20
21	Clerical & General Office Expenses	78,426	21,346	223,805	323,577		323,577	(89,135)	234,442			21
22	Employee Benefits & Payroll Taxes			534,107	534,107		534,107	(5,192)	528,915			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,546	1,546		1,546	499	2,045			24
25	Other Admin. Staff Transportation			4,701	4,701		4,701	581	5,282			25
26	Insurance-Prop.Liab.Malpractice			136,587	136,587		136,587	1,350	137,937			26
27	Other (specify):*							21,071	21,071			27
28	**TOTAL General Administration**	159,241	21,346	1,427,071	1,607,658	(3,321)	1,604,337	(354,891)	1,249,447			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,696,046	455,005	1,697,629	4,848,680	(3,321)	4,845,359	(308,741)	4,536,619			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tri State Nrsing & Rehab Ctr #0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			62,577	62,577		62,577	31,891	94,468			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			503	503		503	62,313	62,816			32
33	Real Estate Taxes			260,760	260,760	3,321	264,081	2,597	266,678			33
34	Rent-Facility & Grounds			378,000	378,000		378,000	(378,000)				34
35	Rent-Equipment & Vehicles			3,389	3,389		3,389	549	3,938			35
36	Other (specify):*			343	343		343	(343)				36
37	**TOTAL Ownership**			705,572	705,572	3,321	708,893	(280,993)	427,900			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		215,223	453,916	669,139		669,139	(7,859)	661,280			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			190,018	190,018		190,018		190,018			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		215,223	643,934	859,157		859,157	(7,859)	851,298			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,696,046	670,228	3,047,135	6,413,409		6,413,409	(597,592)	5,815,817			45

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(77,637)	30		9
10	Interest and Other Investment Income	(8,682)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(155)	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	(90)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(153,246)	21		24
25	Fund Raising, Advertising and Promotional	(15,151)	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	(70,778)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (325,739)		$	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)	(271,854)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (271,854)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (597,593)		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 Nrsing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (8,421)	6	1
2	Lobbying	(1,268)	20	2
3	Patient Clothing	(280)	10	3
4	Theft	(493)	21	4
5	Collection Expense	(7,485)	21	5
6	Amortization	(343)	36	6
7	PAC Dues	(3,401)	20	7
8	Building Company-Mgmt. Fees	(4,200)	17	8
9	Building Company-Bank Charges	(554)	21	9
10	Building Company-Admin. Expenses	(250)	21	10
11	Non Allowable legal	(44,083)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(70,778)		49

Tri State Nrsing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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 Nrsing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			104		5,433							5,537	1
2	Food Purchase	(155)		224									69	2
3	Housekeeping			576		62							638	3
4	Laundry													4
5	Heat and Other Utilities			803		79							882	5
6	Maintenance	(8,421)		1,678	5,027	147							(1,569)	6
7	Other (specify):*				717	751							1,468	7
8	**TOTAL General Services**	(8,576)		3,385	5,744	6,472							7,025	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(280)				22,605	(793)		(503)				21,029	10
10a	Therapy													10a
11	Activities													11
12	Social Services					13,156							13,156	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,940							4,940	15
16	**TOTAL Health Care and Programs**	(280)				40,701	(793)		(503)				39,125	16
	C. General Administration													
17	Administrative	(4,200)	4,200	1,680	9,561	44,021							55,262	17
18	Directors Fees													18
19	Professional Services	(44,083)		(206,911)		(69,683)							(320,677)	19
20	Fees, Subscriptions & Promotions	(19,820)		545		625							(18,650)	20
21	Clerical & General Office Expenses	(162,118)	804	3,384	57,940	10,855							(89,135)	21
22	Employee Benefits & Payroll Taxes				(5,192)								(5,192)	22
23	Inservice Training & Education													23
24	Travel and Seminar			86		413							499	24
25	Other Admin. Staff Transportation			581									581	25
26	Insurance-Prop.Liab.Malpractice			1,006		344							1,350	26
27	Other (specify):*				13,714	7,357							21,071	27
28	**TOTAL General Administration**	(230,221)	5,004	(199,629)	76,023	(6,068)							(354,891)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(239,077)	5,004	(196,244)	81,767	41,105	(793)		(503)				(308,741)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(77,637)	107,784	1,340		404							31,891	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,682)	66,013	4,866		116							62,313	32
33	Real Estate Taxes			2,344		253							2,597	33
34	Rent-Facility & Grounds		(378,000)										(378,000)	34
35	Rent-Equipment & Vehicles			549									549	35
36	Other (specify):*	(343)											(343)	36
37	**TOTAL Ownership**	(86,662)	(204,203)	9,099		773							(280,993)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(7,859)						(7,859)	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**						(7,859)						(7,859)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(325,739)	(199,199)	(187,145)	81,767	41,878	(8,652)		(503)				(597,592)	45

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	32	Interest	148,570	Lansing Healthcare Properties	100.00%		(148,570)	2
3	V	33	Property Tax-Rental	260,760	Lansing Healthcare Properties	100.00%	260,760		3
4	V	17	Management Fees		Lansing Healthcare Properties	100.00%	4,200	4,200	4
5	V	21	Misc Admin Expense		Lansing Healthcare Properties	100.00%	250	250	5
6	V	21	Bank Charges		Lansing Healthcare Properties	100.00%	554	554	6
7	V	30	Depreciation		Lansing Healthcare Properties	100.00%	107,784	107,784	7
8	V	32	Interest		Lansing Healthcare Properties	100.00%	214,583	214,583	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 787,330			$ 588,131	$ * (199,199)	14

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 104	$ 104	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	224	224	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	576	576	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	803	803	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,678	1,678	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,680	1,680	20
21	V	19	Professional Fees	210,264	Extended Care Consulting, LLC	100.00%	3,353	(206,911)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	545	545	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	3,384	3,384	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	86	86	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	581	581	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,006	1,006	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,340	1,340	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,866	4,866	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,344	2,344	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	549	549	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			$ 23,119	$ * (187,145)	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	5,027	$ 5,027	15
16	V	06	Maintenance (Direct)	1,886	Extended Care Consulting, LLC	100.00%	1,886		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	471	471	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	246	246	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,561	9,561	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	57,940	57,940	22
23	V	21	Office and Clerical (Direct)	15,421	Extended Care Consulting, LLC	100.00%	15,421		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	12,346	12,346	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,368	1,368	25
26	V	22	Employee Benefits	5,192	Extended Care Consulting, LLC	100.00%		(5,192)	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			$ 22,499			$ 104,266	$ * 81,767	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 62	$ 62	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	79	79	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	147	147	17
18	V	19	Professional Fees	70,092	Extended Care Clinical, LLC	100.00%	409	(69,683)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	625	625	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,624	1,624	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	413	413	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	344	344	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	404	404	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	116	116	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	253	253	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	5,433	5,433	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	751	751	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	22,605	22,605	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	13,156	13,156	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,940	4,940	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	44,021	44,021	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	9,231	9,231	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	7,357	7,357	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 70,092			$ 111,970	$ * 41,878	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 11,013	MAC Rx, LLC	100.00%	$ 10,220	$ (793)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	109,115	MAC Rx, LLC	100.00%	101,257	(7,859)	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			$ 120,129			$ 111,477	$ * (8,652)	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 155,889	$ 155,889	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	155,889	CCS Employee Benefits Group	100.00%		(155,889)	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			$ 155,889			$ 155,889	$ *	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Various Equipment	8,640	Vent Lease LLC	100.00%	8,137	$ (503)	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			$ 8,640			$ 8,137	$ * (503)	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	1
2	DANIEL ROTHNER TRUST	4.7619%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	2
3	ERIC ROTHNER	1.1905%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	3
4	KATHRYN VALES TRUST	4.7619%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	4
5	KIMBERLY RICHMAN TRUST	4.7619%	GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	MELISSA ROTHNER TRUST	4.7619%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	6
7	NATHAN AND SHIRLEY ROTHNER FAMILY TRUST	65.4762%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	7
8	RACHEL ROTHNER TRUST	4.7619%	MAJOR HOSPITAL DYER	DYER, IN	LANSING HEALTHCARE PROPE	LANSING	BUILDING COMPANY	8
9	WILLIAM ROTHNER TRUST	4.7619%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			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 Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	N/A	See Attached	0.79	1.98%	Alloc. Sal.	$ 1,453	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.59	2.89%	Alloc Fee/Sal	5,773	17-7	2
3	Kimberly Rudolph	Relative	Clerical	N/A	See Attached	0.15	1.97%	Alloc. Sal.	47	21-7	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	$ 7,273		13

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,380,761	34	$ 5,206	$	27,609	$ 104	1
2	02	Food	Patient Days	1,380,761	34	11,203		27,609	224	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		27,609	576	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		27,609	803	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		27,609	1,678	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		27,609	1,680	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		27,609	3,353	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		27,609	545	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		27,609	3,384	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		27,609	86	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		27,609	581	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		27,609	1,006	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		27,609	1,340	13
14	32	Interest	Patient Days	1,380,761	34	243,379		27,609	4,866	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		27,609	2,344	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		27,609	549	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 23,119	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,380,761	34	251,431	251,431	27,609	5,027	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		1,886	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		27,609	471	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			246	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	27,609	9,561	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	27,609	57,940	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		15,421	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		27,609	12,346	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			1,368	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,222,483	$ 4,461,323		$ 104,266	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	818,091	19	$ 1,844	$	27,609	$ 62	1
2	05	Utilities	Patient Days	818,091	19	2,355		27,609	79	2
3	06	Maintenance	Patient Days	818,091	19	4,352		27,609	147	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		27,609	409	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		27,609	625	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		27,609	1,624	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		27,609	413	7
8	26	Insurance	Patient Days	818,091	19	10,196		27,609	344	8
9	30	Depreciation	Patient Days	818,091	19	11,978		27,609	404	9
10	32	Interest	Patient Days	818,091	19	3,446		27,609	116	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		27,609	253	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	27,609	5,433	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		27,609	751	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	27,609	22,605	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	27,609	13,156	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		27,609	4,940	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	27,609	44,021	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	27,609	9,231	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		27,609	7,357	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,317,844	$ 2,798,561		$ 111,970	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 10,220	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						101,257	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					$	$		$ 111,477	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 155,889	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					$	$		$ 155,889	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	10	Various Equipment	Direct Allocation						8,137	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					$	$		$ 8,137	25

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 2,582,000			$ 148,570	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	DAIWA		X	Line of Credit							503	6
7	Lemont Property		X	Loan				1,082,177			66,013	7
8					-							8
9	TOTAL Facility Related						$	$ 3,664,177			$ 215,086	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,682)	10
11	Interest Income-Building Co.		X								(148,570)	11
12	Alloc from Extended Care Consulting		X								4,866	12
13	Alloc from Extended Care Clinical		X		-						116	13
14	TOTAL Non-Facility Related						$	$			$ (152,270)	14
15	TOTALS (line 9+line14)						$	$ 3,664,177			$ 62,816	15

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 266,164	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.)		$ 259,633	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,531)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 269,888	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.)		$ 3,321	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.		$ 266,678	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	176,370	8
	2012	188,666	9
	2013	202,955	10
	2014	262,191	11
	2015	257,036	12

2016 Accrual = $257,036 x 1.05 = $269,888

Allocated from Extended Care Consulting LLC: $2,344

Allocated from Extended Care Clinical LLC: $253

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri State Nrsing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 257,036.02	$ 257,036.02
2.			$	$
3.	See Attached	Allocated from 2201 W. Main	$ 167,518.13	$ 2,597.46
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 424,554.15	$ 259,633.48

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri State Nrsing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			12,715	2
3	TOTALS			$ 97,701	3

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 107,784	39	$	$ (107,784)	$ 2,932,035	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20			24,426	9
10	Various			1996	82,791		20	1,151	1,151	82,777	10
11	Various			1997	44,854		20	2,243	2,243	43,771	11
12	Various			1998	47,497		20	2,004	2,004	44,709	12
13	Various			1999	39,389		20	1,969	1,969	34,905	13
14	Various			2000	13,995		20	700	700	11,515	14
15	Various			2001	20,621		20	1,031	1,031	16,172	15
16	Various			2002	8,353		20	107	107	7,719	16
17	Various			2003	20,578		20	540	540	18,193	17
18	Various			2004	61,438		20	87	87	60,778	18
19	Various			2005	140,855		20	3,777	3,777	139,837	19
20	Various			2006	29,295		20	1,034	1,034	26,291	20
21	Various			2007	49,428		20	1,625	1,625	48,519	21
22	Various			2008	83,465		20	4,801	4,801	75,701	22
23	Various			2009	28,775		20	2,878	2,878	20,037	23
24	Various			2010	11,849		20	911	911	5,736	24
25	Various			2011	164,873		20	13,600	13,600	77,917	25
26	Various			2012	19,880		20	2,568	2,568	12,191	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2,559	67
68	Related Party Allocations (Pages 12H & 12I)		60,366	840		840		40,675	68
69	Financial Statement Depreciation			62,577			(62,577)		69
70	TOTAL (lines 4 thru 69)		$ 3,891,917	$ 171,201		$ 42,223	$ (128,978)	$ 3,726,461	70

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,891,917	$ 171,201		$ 42,223	$ (128,978)	$ 3,726,461	1
2	62 New Replacement Windows	2013	32,250		20	3,225	3,225	12,094	2
3	Remove & Install New Condensing Unit	2013	26,500		20	2,650	2,650	9,938	3
4	Walk-In Freezer - Kitchen	2013	7,296		20	1,459	1,459	5,350	4
5	3 Additional Replacement Windows	2013	4,180		20	418	418	1,498	5
6	New Fence	2013	3,275		20	328	328	1,174	6
7	Removed Asphalt, Restriped Parking Lot	2013	98,256		20	6,554	6,554	20,477	7
8	American Standard Hvac Unit	2013	7,100		20	710	710	2,189	8
9	South Wing Hvac System Replacement	2014	36,749		20	1,837	1,837	4,747	9
10	40 Yellow And 3 Blue Parking Bumpers	2014	4,702		20	313	313	731	10
11	Door System - Double Door, Installation Of Door Wander Control	2015	13,512		20	676	676	1,295	11
12	Replace Roof Over Boiler Rm/Roof Repair/16 Sheets Plywood/Alu	2015	9,000		20	450	450	600	12
13	Replace Bad Condensor - Rewire Power & Control To Unit	2015	2,599		20	130	130	206	13
14	1 Recirculation Pump	2016	4,246		20	195	195	195	14
15	Landscape Renovation - Courtyard & East Entrance	2016	16,515		20	482	482	482	15
16	Electrical Work	2016	8,137		20	237	237	237	16
17	Office Area Condensing Unit	2016	2,697		20	56	56	56	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)		$ 4,168,930	$ 171,201		$ 61,943	$ (109,258)	$ 3,787,729	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,168,930	$ 171,201		$ 61,943	$ (109,258)	$ 3,787,729	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)		$ 4,168,930	$ 171,201		$ 61,943	$ (109,258)	$ 3,787,729	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,168,930	$ 171,201		$ 61,943	$ (109,258)	$ 3,787,729	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)		$ 4,168,930	$ 171,201		$ 61,943	$ (109,258)	$ 3,787,729	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,168,930	$ 171,201		$ 61,943	$ (109,258)	$ 3,787,729	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)		$ 4,168,930	$ 171,201		$ 61,943	$ (109,258)	$ 3,787,729	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Heating Repairs	2008	7,149		20	357	357	2,559	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	$ 2,559	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 2,559	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	$ 2,559	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	15,813	405	39	405		5,795	3
4									4
5	Allocated from Extended Care Consulting, LLC	2007	4,799	106	39	106		1,010	5
6	Allocated from Extended Care Clinical, LLC	2002	1,709	44	39	44		626	6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	92	5	20	5		46	9
10	Allocated from Extended Care Consulting, LLC	2009	55	3	20	3		22	10
11	Allocated from Extended Care Consulting, LLC	2010	539	27	20	27		189	11
12	Allocated from Extended Care Consulting, LLC	2011	194	10	20	10		58	12
13	Allocated from Extended Care Consulting, LLC	2012	64	3	20	3		16	13
14	Allocated from Extended Care Consulting, LLC	2014	887	44	20	44		133	14
15	Allocated from Extended Care Consulting, LLC	2016	1,063	53	20	53		53	15
16									16
17		2002	13,062		20			13,062	17
18	Allocated from 2201 W. Main, LLC	2003	15,394		20			15,394	18
19	Allocated from 2201 W. Main, LLC	2005	765	1	20	1		765	19
20	Allocated from 2201 W. Main, LLC	2009	138	7	20	7		55	20
21	Allocated from 2201 W. Main, LLC	2014	1,284	64	20	64		193	21
22	Allocated from 2201 W. Main, LLC	2015	218	11	20	11		22	22
23	Allocated from 2201 W. Main, LLC	2016	860	43	20	43		43	23
24									24
25	Allocated from Extended Care Clinical, LLC	2002	1,412		20			1,412	25
26	Allocated from Extended Care Clinical, LLC	2003	1,664		20			1,664	26
27	Allocated from Extended Care Clinical, LLC	2005	83		20			83	27
28	Allocated from Extended Care Clinical, LLC	2009	15	1	20	1		6	28
29	Allocated from Extended Care Clinical, LLC	2014	139	7	20	7		21	29
30	Allocated from Extended Care Clinical, LLC	2015	24	1	20	1		2	30
31	Allocated from Extended Care Clinical, LLC	2016	93	5	20	5		5	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 60,366	$ 840		$ 840	$	$ 40,675	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 60,366	$ 840		$ 840	$	$ 40,675	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)		$ 60,366	$ 840		$ 840	$	$ 40,675	34

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 254,284	$ 456	$ 31,586	$ 31,130	10	$ 168,156	71
72	Current Year Purchases	8,421		491	491	10	491	72
73	Fully Depreciated Assets	439,775				10	439,775	73
74								74
75	TOTALS	$ 702,479	$ 456	$ 32,077	$ 31,621		$ 608,422	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, L	2015	3,609	102	102		5	3,405	77
78		Allocated from EC Clinical, LLC	2012	1,734	347	347		5	1,553	78
79										79
80	TOTALS			$ 52,551	$ 449	$ 449	$		$ 40,366	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)	$ 5,021,661	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 172,106	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 94,469	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (77,637)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,436,517	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,938 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$		$ 146,520	$		$ 146,520	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			105,435			105,435	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			201,933			201,933	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				108,212		108,212	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					28	107,011		107,039	13
14	TOTAL			$		$ 453,916	$ 215,223		$ 669,139	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.

Facility Name & ID Number Tri State Nrsing & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 2,977	$ 100,502	1
2	Cash-Patient Deposits	29,942	29,942	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	96,794	96,794	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,243	157,243	6
7	Other Prepaid Expenses	1,898	1,898	7
8	Accounts Receivable (owners or related parties)		3,738,022	8
9	Other(specify): See Attached Schedule	58,893	244,942	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 347,747	$ 4,369,343	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	1,071,536	1,071,536	15
16	Equipment, at Historical Cost	495,000	495,000	16
17	Accumulated Depreciation (book methods)	(1,258,816)	(3,549,370)	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): See Attached Schedule	1,421	1,421	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 309,141	$ 1,111,127	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 656,888	$ 5,480,470	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,426,232	$ 1,426,231	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,075	22,075	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,429	98,429	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,032	4,032	31
32	Accrued Real Estate Taxes(Sch.IX-B)	269,888	269,888	32
33	Accrued Interest Payable		12,049	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,820,656	$ 1,832,704	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,082,177	39
40	Mortgage Payable		2,582,000	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	$ 3,664,177	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,310,599	$ 5,496,881	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,653,711)	$ (16,411)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 656,888	$ 5,480,470	48

***(See instructions.)**

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (887,761)	1
2	Restatements (describe):		2
3	**Rounding**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (887,758)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	31,514	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	(797,467)	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)**	$ (765,953)	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)**	$ (1,653,711)	24 *

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

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,261,132	1
2	Discounts and Allowances for all Levels	(1,897,040)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,364,092	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,928,453	6
7	Oxygen	5,492	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,933,945	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	112,791	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,400	19
20	Radiology and X-Ray	8,180	20
21	Other Medical Services	2,833	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 138,204	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,682	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,682	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,444,923	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	907,203	31
32	Health Care	2,333,819	32
33	General Administration	1,607,658	33
	B. Capital Expense		
34	Ownership	705,572	34
	C. Ancillary Expense		
35	Special Cost Centers	669,139	35
36	Provider Participation Fee	190,018	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,413,409	40
41	**Income before Income Taxes (line 30 minus line 40)****	31,514	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 31,514	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,693,477	44
45	Private Pay - Net Inpatient Revenue	553,001	45
46	Medicare - Net Inpatient Revenue	81,080	46
47	Other-(specify) Hospice	19,672	47
48	Other-(specify) Insurance	16,862	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,364,092	49

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

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

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

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

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,925	1,933	$ 84,861	$ 43.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,557	8,367	258,355	30.88	3
4	Licensed Practical Nurses	22,659	24,719	691,664	27.98	4
5	CNAs & Orderlies	46,059	50,033	522,667	10.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,062	10,174	192,166	18.89	8
9	Activity Director	1,495	1,608	26,004	16.17	9
10	Activity Assistants	7,831	8,511	75,601	8.88	10
11	Social Service Workers	6,417	6,843	143,976	21.04	11
12	Dietician					12
13	Food Service Supervisor	2,011	2,135	52,178	24.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,415	5,801	59,969	10.34	15
16	Dishwashers	9,707	10,584	119,592	11.30	16
17	Maintenance Workers	2,085	2,257	59,767	26.48	17
18	Housekeepers	10,524	11,120	107,215	9.64	18
19	Laundry	5,010	5,756	70,719	12.29	19
20	Administrator	2,073	2,077	80,815	38.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,941	6,447	78,426	12.16	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	2,080	2,046	37,961	18.55	31
32	Other Health Care(specify)					32
33	Other(specify)	2,054	2,238	34,110	15.24	33
34	TOTAL (lines 1 - 33)	149,905	162,649	$ 2,696,046 *	$ 16.58	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	191	$ 10,880	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	5,875	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7	484	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)	198	$ 35,239		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	187	$ 9,336	10-03	50
51	Licensed Practical Nurses	472	18,858	10-03	51
52	Certified Nurse Assistants/Aides	1,056	26,415	10-03	52
53	TOTAL (lines 50 - 52)	1,715	$ 54,609		53

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sarah Simons	Administrator	0	$ 39,328
Niki Mehta	Administrator	0	41,487
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,815

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
DAIWA	Line of Credit	$ 2,846
Navex Global	Software Compliance	102
Advanced Discovery	e Discovery & Litigation Suppor	164
Pinnacle Quality Insight	Customer Satisfaction	2,256
Bylmas	Tax Credit Services	3,037
Legat Architects	Architectural Services	4,245
Benefit Services Group	Benefits Consulting	547
Coburn Enterprises	Web Development	12
Extended Care Consulting LLC	Home Office Expense	210,264
Extended Care Clinical LLC	Home Office Expense	70,092
See Supplemental Schedule		181,665
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 475,231

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,484
Unemployment Compensation Insurance	56,271
FICA Taxes	206,170
Employee Health Insurance	153,894
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	
Pension Exp	21,605
Other Employee Welfare	10,124
Holiday Expense	3,367
TOTAL (agree to Schedule V, line 22, col.8)	$ 528,915

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,545
Health Care Worker Background Check	1,790
(Indicate # of checks performed 120)	
Patient Background Checks	
Dues and Subscriptions	13,733
License and Permits	5,206
Alloc from Extended Care Consulting	545
Alloc from Extended Care Clinical	625
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,444

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,546
Alloc from Extended Care Consulting	86
Alloc from Extended Care Clinical	413
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,045

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Tri State Nrsing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $10,307**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **33,820** 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 fo
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 Departmen
during this cost report period. $ **190,018**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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 1**
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
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