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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0048678

Facility Name: South Suburban Rehabilitation Center

Address: 19000 South Halsted Street (Number) Homewood (City) 60430 (Zip Code)

County: Cook

Telephone Number: (708) 957-9200 **Fax #** (708) 957-7828

HFS ID Number:

Date of Initial License for Current Owners: 04/01/2007

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	259	Skilled (SNF)	259	94,535	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,535	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	34,341	2,043	5,936	42,320	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,341	2,043	5,936	42,320	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.77%

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 01/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [X] If YES, enter number of beds certified 259 and days of care provided 5,928

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	232,879	51,689	9,740	294,308		294,308	2,145	296,453			1
2	Food Purchase		215,534		215,534		215,534	202	215,736			2
3	Housekeeping	152,774	48,893	202	201,869		201,869	(2,527)	199,342			3
4	Laundry	61,292	18,625		79,917		79,917	(641)	79,276			4
5	Heat and Other Utilities			159,466	159,466		159,466	984	160,450			5
6	Maintenance	133,697		122,686	256,383		256,383	3,945	260,328			6
7	Other (specify):*							1,603	1,603			7
8	**TOTAL General Services**	580,642	334,741	292,094	1,207,477		1,207,477	5,711	1,213,188			8
	B. Health Care and Programs											
9	Medical Director			17,500	17,500		17,500		17,500			9
10	Nursing and Medical Records	2,204,625	117,080	26,261	2,347,966		2,347,966	15,235	2,363,201			10
10a	Therapy	136,029			136,029		136,029	3,027	139,056			10a
11	Activities	113,422	17,269	275	130,966		130,966		130,966			11
12	Social Services	142,344	59	10,615	153,018		153,018	2,165	155,183			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,043	7,043			15
16	**TOTAL Health Care and Programs**	2,596,420	134,408	54,651	2,785,479		2,785,479	27,470	2,812,949			16
	C. General Administration											
17	Administrative	87,863			87,863		87,863	38,837	126,700			17
18	Directors Fees											18
19	Professional Services			295,260	295,260	(20,000)	275,260	(170,244)	105,016			19
20	Dues, Fees, Subscriptions & Promotions			31,244	31,244		31,244	(5,352)	25,892			20
21	Clerical & General Office Expenses	88,470	27,604	279,787	395,861		395,861	(118,427)	277,435			21
22	Employee Benefits & Payroll Taxes			559,067	559,067		559,067	(13,192)	545,875			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,854	6,854		6,854	1,149	8,003			24
25	Other Admin. Staff Transportation			1,188	1,188		1,188	559	1,747			25
26	Insurance-Prop.Liab.Malpractice			216,306	216,306		216,306	(47,365)	168,941			26
27	Other (specify):*							21,535	21,535			27
28	**TOTAL General Administration**	176,333	27,604	1,389,706	1,593,643	(20,000)	1,573,643	(292,499)	1,281,144			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,353,395	496,753	1,736,451	5,586,599	(20,000)	5,566,599	(259,318)	5,307,281			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center #0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,601	14,601		14,601	92,021	106,622			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,496	137,496		137,496	191,727	329,223			32
33	Real Estate Taxes			266,032	266,032	20,000	286,032	1,427	287,459			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(359,117)	883			34
35	Rent-Equipment & Vehicles			1,486	1,486		1,486	1,583	3,069			35
36	Other (specify):*											36
37	TOTAL Ownership			779,615	779,615	20,000	799,615	(72,359)	727,256			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		340,321	574,982	915,303		915,303	(57,246)	858,057			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,803	141,803		141,803		141,803			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		340,321	716,785	1,057,106		1,057,106	(57,246)	999,860			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,353,395	837,074	3,232,851	7,423,320		7,423,320	(388,923)	7,034,397			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	(28,140)	30		9
10	Interest and Other Investment Income	(19,232)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(104)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(218,411)	21		24
25	Fund Raising, Advertising and Promotional	(7,537)	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	(225,573)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (498,998)		$	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)	110,075		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 110,075		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (388,923)		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

SEE ACCOUNTANTS' COMPILATION REPORT

South Suburban Rehabilitation Center

ID# 0048678

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty	$ (34)	10	1
2	Theft Loss	(1,399)	21	2
3	Mics. Income - Medical Records	(83)	21	3
4	Annual Report	(250)	20	4
5	Collection Expense	(440)	21	5
6	Prior Period ADJ - Insurance Premium ADJ	(48,097)	26	6
7	Bldg. Co. - Amortization	(157,950)	31	7
8	Bldg. Co. - Bank Charge	(426)	21	8
9	Bldg. Co. - Filling Fee	(250)	20	9
10	Bldg. Co. - Legal fees	(2,445)	19	10
11	Capitalized R&M	(4,200)	06	11
12	Non-Allowable PY Legal	(10,000)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(225,573)		49

South Suburban Rehabilitation Center

ID# 0048678

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			110		3,252		(1,217)					2,145	1
2	Food Purchase	(104)		306									202	2
3	Housekeeping			393		43					(2,963)		(2,527)	3
4	Laundry										(641)		(641)	4
5	Heat and Other Utilities			893		91							984	5
6	Maintenance	(4,200)		2,567	5,507	91					(20)		3,945	6
7	Other (specify):*				1,147	456							1,603	7
8	**TOTAL General Services**	(4,304)		4,269	6,654	3,933		(1,217)			(3,624)		5,711	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)				20,929		(134)		(25)	(5,501)		15,235	10
10a	Therapy					3,027							3,027	10a
11	Activities													11
12	Social Services					2,165							2,165	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					3,661	3,382						7,043	15
16	**TOTAL Health Care and Programs**	(34)				29,782	3,382	(134)		(25)	(5,501)		27,470	16
	C. General Administration													
17	Administrative			1,819	7,065	29,953							38,837	17
18	Directors Fees													18
19	Professional Services	(12,445)	2,445	(143,771)		(16,473)							(170,244)	19
20	Fees, Subscriptions & Promotions	(8,037)	250	2,306		129							(5,352)	20
21	Clerical & General Office Expenses	(220,759)	426	10,776	85,629	5,501							(118,427)	21
22	Employee Benefits & Payroll Taxes				(9,810)		(3,382)						(13,192)	22
23	Inservice Training & Education													23
24	Travel and Seminar			113		1,036							1,149	24
25	Other Admin. Staff Transportation			559									559	25
26	Insurance-Prop.Liab.Malpractice	(48,097)		614		118							(47,365)	26
27	Other (specify):*				16,736	4,799							21,535	27
28	**TOTAL General Administration**	(289,337)	3,121	(127,584)	99,620	25,063	(3,382)						(292,499)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(293,675)	3,121	(123,315)	106,274	58,778		(1,351)		(25)	(9,125)		(259,318)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **South Suburban Rehabilitation Center** **# 0048678** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(28,140)	116,218	3,316		627							92,021	30
31	Amortization of Pre-Op. & Org.	(157,950)	157,950											31
32	Interest	(19,232)	192,676	6,329		11,954							191,727	32
33	Real Estate Taxes			1,285		142							1,427	33
34	Rent-Facility & Grounds		(360,000)	883									(359,117)	34
35	Rent-Equipment & Vehicles			1,583									1,583	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(205,322)	106,844	13,396		12,723							(72,359)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(4,791)	(46,071)	(692)	(5,692)		(57,246)	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**							(4,791)	(46,071)	(692)	(5,692)		(57,246)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(498,998)	109,965	(109,919)	106,274	71,501		(6,142)	(46,071)	(717)	(14,816)		(388,923)	45

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Homewood Mercy Properties, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 Income	$ 360,000	Homewood Mercy Property, LLC.		$	$ (360,000)	1
2	V	32	Interest	19,167	Homewood Mercy Property, LLC.		211,843	192,676	2
3	V	33	Real Estate Tax Expense	266,032	Homewood Mercy Property, LLC.		266,032		3
4	V	31	Amortization - Goodwill		Homewood Mercy Property, LLC.		153,333	153,333	4
5	V	31	Amortization - Loan Fees		Homewood Mercy Property, LLC.		4,617	4,617	5
6	V	21	Bank Charge		Homewood Mercy Property, LLC.		426	426	6
7	V	30	Depreciation Expense		Homewood Mercy Property, LLC.		116,218	116,218	7
8	V	20	Filing Fee		Homewood Mercy Property, LLC.		250	250	8
9	V	19	Legal Fees		Homewood Mercy Property, LLC.		2,445	2,445	9
10	V				Homewood Mercy Property, LLC.				10
11	V				Homewood Mercy Property, LLC.				11
12	V								12
13	V								13
14	Total			$ 645,199			$ 755,164	$ * 109,965	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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%	$ 110	$ 110	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	306	306	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	393	393	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	893	893	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,567	2,567	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,819	1,819	20
21	V	19	Professional Fees	151,355	Extended Care Consulting, LLC	100.00%	7,584	(143,771)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,306	2,306	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,776	10,776	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	113	113	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	559	559	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	614	614	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,316	3,316	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,329	6,329	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,285	1,285	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	883	883	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,583	1,583	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 151,355			$ 41,436	$ * (109,919)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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%	5,507	$ 5,507	15
16	V	06	Maintenance (Direct)	2,541	Extended Care Consulting, LLC	100.00%	2,541		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	920	920	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	227	227	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	7,065	7,065	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	85,629	85,629	22
23	V	21	Office and Clerical (Direct)	13,933	Extended Care Consulting, LLC	100.00%	13,933		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,489	15,489	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,247	1,247	25
26	V	22	Employee Benefits	9,810	Extended Care Consulting, LLC	100.00%		(9,810)	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			$ 26,284			$ 132,558	$ * 106,274	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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%	$ 43	$ 43	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	91	91	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	91	91	17
18	V	19	Professional Fees	43,112	Extended Care Clinical, LLC	100.00%	5,083	(16,473)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	129	129	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,214	1,214	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,036	1,036	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	118	118	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	627	627	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	11,954	11,954	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	142	142	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	3,252	3,252	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	456	456	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	20,929	20,929	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	3,027	3,027	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	2,165	2,165	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,661	3,661	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	29,953	29,953	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,287	4,287	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	4,799	4,799	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 43,112			$ 93,057	$ * 71,501	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing Salary	20,976	Extended Care Clinical, LLC	100.00%	20,976		17
18	V	12	Social Service Salary	9,730	Extended Care Clinical, LLC	100.00%	9,730		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,382	3,382	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	3,382	Extended Care Clinical, LLC	100.00%		(3,382)	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			$ 34,088			$ 34,088	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	$ 2,740	Care Centers Health Systems, Inc.	100.00%	$ 1,523	$ (1,217)	15
16	V	10	Nursing Supplies	301	Care Centers Health Systems, Inc.	100.00%	167	(134)	16
17	V	39	Ancillary Expense	10,785	Care Centers Health Systems, Inc.	100.00%	5,994	(4,791)	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			$ 13,826			$ 7,684	$ * (6,142)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 572,458	TriCare Rehab	100.00%	$ 526,387	$ (46,071)	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			$ 572,458			$ 526,387	$ * (46,071)	39

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	6	R&M - Equipment	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies	321	Reliable Medical of the Midwest, LLC	100.00%	296	(25)	16
17	V	39	Ancillary Expense	8,830	Reliable Medical of the Midwest, LLC	100.00%	8,138	(692)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,151			$ 8,434	$ * (717)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	44,466	Xcel Supply, LLC	100.00%	41,503	(2,963)	16
17	V	4	Laundry	9,620	Xcel Supply, LLC	100.00%	8,979	(641)	17
18	V	6	Repairs & Maintenance	297	Xcel Supply, LLC	100.00%	277	(20)	18
19	V	10	Nursing	82,543	Xcel Supply, LLC	100.00%	77,042	(5,501)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	85,410	Xcel Supply, LLC	100.00%	79,718	(5,692)	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			$ 222,335			$ 207,519	$ * (14,816)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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%	$ 109,047	$ 109,047	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	109,047	CCS Employee Benefits Group	100.00%		(109,047)	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			$ 109,047			$ 109,047	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	51.00%	See Attached	1.05	2.26%		$		1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.54	2.80%	Alloc. Salary	4,474	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.57	1.43%	Alloc. Salary	1,002	22-7	3
4	G. Matt Silvers	Relative	Administrative	N/A	See Attached	0.39	1.83%	Alloc. Salary	1,322	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,798		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 South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,512,273	34	$ 3,931	$	42,320	$ 110	1
2	02	Food	Patient Days	1,512,273	34	10,940		42,320	306	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		42,320	393	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		42,320	893	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		42,320	2,567	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		42,320	1,819	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		42,320	7,584	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		42,320	2,306	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		42,320	10,776	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		42,320	113	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		42,320	559	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		42,320	614	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		42,320	3,316	13
14	32	Interest	Patient Days	1,512,273	34	226,162		42,320	6,329	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		42,320	1,285	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		42,320	883	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		42,320	1,583	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 41,436	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,512,273	34	196,794	196,794	42,320	5,507	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478		2,541	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		42,320	920	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607			227	4
5	12	Admission (Direct)	Direct		34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	42,320	7,065	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	42,320	85,629	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		13,933	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		42,320	15,489	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			1,247	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					$ 5,054,827	$ 4,364,695		$ 132,558	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	42,320	$ 43	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		42,320	91	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		42,320	91	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		42,320	5,083	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		42,320	129	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		42,320	1,214	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		42,320	1,036	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		42,320	118	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		42,320	627	9
10	32	Interest	Patient Days	1,512,273	34	427,165		42,320	11,954	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		42,320	142	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	42,320	3,252	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		42,320	456	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	42,320	20,929	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	42,320	3,027	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	42,320	2,165	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		42,320	3,661	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	42,320	29,953	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	42,320	4,287	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		42,320	4,799	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 93,057	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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 Salary	Direct Allocation			$ 15,960	$ 15,960		$	1
2	07	Emp. Ben. - General	Direct Allocation			1,662				2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		20,976	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		9,730	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			3,382	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 34,088	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 1,523	1
2	10	Nursing Supplies	Direct Allocation						167	2
3	39	Ancillary Expense	Direct Allocation						5,994	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					$	$		$ 7,684	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation			$	$		$ 526,387	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					$	$		$ 526,387	25

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
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	6	R&M - Equipment	Direct Allocation			$	$		$	1
2	10	Nursing Supplies	Direct Allocation						296	2
3	39	Ancillary Expense	Direct Allocation						8,138	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					$	$		$ 8,434	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						41,503	2
3	4	Laundry	Direct Allocation						8,979	3
4	6	Repairs & Maintenance	Direct Allocation						277	4
5	10	Nursing	Direct Allocation						77,042	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation							10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						79,718	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					$	$		$ 207,519	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			$	$		$ 109,047	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					$	$		$ 109,047	25

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank Leumi		X				$	$			$ 30,480	1
2	National City / Ridgeland		X	Mortgage Loan				2,341,928			121,925	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Stein	X		Working Capital Loan		01/01/10			06/21/10		30,333	6
7	Lake Forest		X								56,575	7
8	See Supplemental Schedule										128,308	8
9	TOTAL Facility Related						$	$ 2,341,928			$ 367,621	9
	B. Non-Facility Related*											
10	Interest Income		X								(19,232)	10
11	Interest Income - Bldg Co.		X								(19,167)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (38,399)	14
15	TOTALS (line 9+line14)						$	$ 2,341,928			$ 329,222	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Cole Taylor Bank		X				$	$			$ 18,293	8
9	The Private Bank & Trust		X								19,761	9
10	DIAWA		X								71,972	10
11	Alloc from Ext Care Cnsult		X								6,329	11
12	Alloc from Ext Care Clinical		X								11,954	12
13												13
14	TOTAL Working Capital										128,308	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 South Suburban Rehabilitation Center # 0048678 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	241,502	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.)	$	249,005	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,503	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	259,957	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.	$	20,000	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.	$	287,460	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006	445,015	9
2007	172,220	10
2008	233,674	11
2009	247,578	12

The prior year ending accrual was adjusted to reflect the accrual for the current year R/E taxes only
2010 Accrual (2009 R/E Tax $247,578 x 1.05 = $259,957)
Alloc from Extended Care Consulting, LLC $1,285
Alloc from Extended Care Clinical $142

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-05-400-011-0000	Long Term Care Property	$ 247,577.63	$ 247,577.63
2.	See Attached	Allocated from 2201 Main, LLC	$ 116,500.56	$ 1,459.15
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 364,078.19	$ 249,036.78

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 & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

IMPORTANT NOTICE

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

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

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

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

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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		2007	$ 600,000	1
2	Allocated from ECC			10,270	2
3	TOTALS			$ 610,270	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		3,196,000	116,218		91,314	(24,904)	365,256	67
68	Related Party Allocations (Pages 12H & 12I)		41,391	2,818		2,818		19,728	68
69	Financial Statement Depreciation			14,601			(14,601)		69
70	TOTAL (lines 4 thru 69)		$ 3,237,391	$ 133,637		$ 94,132	$ (39,505)	$ 384,984	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,237,391	$ 133,637		$ 94,132	$ (39,505)	$ 384,984	1
2	Replace Walk-In Cooler Doors	2007	4,750		20	679	679	2,375	2
3	Remove 15 Doors	2007	10,000		20	500	500	1,708	3
4	Smoke Detector	2007	9,691		20	1,384	1,384	4,615	4
5	Preventer, 8000-F Strainer & Acces.	2007	5,365		20	268	268	849	5
6	Roof Repair	2007	2,500		20	125	125	438	6
7	Backflow Preventer Installation	2008	5,365		20	268	268	805	7
8	Install Floor In Walk-In Freezer	2008	3,600		20	180	180	540	8
9	Exterior Street Sign - Double Faced	2008	7,716		20	514	514	1,543	9
10	Exterior Street Sign	2008	8,941		20	596	596	1,788	10
11	Security System	2008	3,380		20	169	169	437	11
12	New Laundry Room 2Nd Floor	2008	2,530		20	127	127	306	12
13	Install New Metal Doors With Frame	2008	3,750		20	188	188	406	13
14	Roofing	2008	2,500		20	125	125	375	14
15	Roofing	2008	900		20	45	45	135	15
16	Plumbing	2008	2,850		20	143	143	428	16
17	Smoke Dampers	2009	26,600		20	1,330	1,330	2,549	17
18	Security System For Front Door	2009	2,644		20	529	529	573	18
19	Sidewalk	2010	3,565		20	158	158	158	19
20	4 Locks	2010	3,250		20	379	379	379	20
21	Walk In Freezer	2010	5,100		20	510	510	510	21
22	Shower Renovation	2010	14,701		20	184	184	184	22
23	Ceramic Tile In Kitchen	2010	5,550		20	46	46	46	23
24	Roof Repairs - East & West Sides	2010	4,200		20	210	210	210	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,376,839	$ 133,637		$ 102,789	$ (30,848)	$ 406,341	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,376,839	$ 133,637		$ 102,789	$ (30,848)	$ 406,341	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,376,839	$ 133,637		$ 102,789	$ (30,848)	$ 406,341	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,376,839	$ 133,637		$ 102,789	$ (30,848)	$ 406,341	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,376,839	$ 133,637		$ 102,789	$ (30,848)	$ 406,341	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,376,839	$ 133,637		$ 102,789	$ (30,848)	$ 406,341	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,376,839	$ 133,637		$ 102,789	$ (30,848)	$ 406,341	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	259 Bed Building	1976	3,196,000	116,218	35	91,314	(24,904)	365,256	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	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 (12F & 12G lines 1 thru 33)		$ 3,196,000	$ 116,218		$ 91,314	$ (24,904)	$ 365,256	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	1,404	36	39	36		299	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	12,749	327	39	327		2,710	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2002	10,531	962	20	962		6,746	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2003	12,411	1,134	20	1,134		7,950	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2005	617	66	20	66		288	12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2009	111	6	20	6		11	13
14									14
15									15
16	Allocated from Extended Care Consulting, LLC	2007	129	6	20	6		26	16
17	Allocated from Extended Care Consulting, LLC	2009	77	4	20	4		8	17
18	Allocated from Extended Care Consulting, LLC	2010	755	38	20	38		38	18
19									19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,160	106	20	106		743	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,367	125	20	125		876	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	68	7	20	7		32	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	12	1	20	1		1	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 41,391	$ 2,818		$ 2,818	$	$ 19,728	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 6,312	$ 631	$ 631	$	10	$ 3,577	71
72	Current Year Purchases	20,205	41	2,749	2,708	10	2,749	72
73	Fully Depreciated Assets	2,151,320				10	2,151,320	73
74								74
75	TOTALS	$ 2,177,837	$ 672	$ 3,380	$ 2,708		$ 2,157,646	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. From EC Clinical	2009	$ 1,564	$ 313	$ 313	$	5	$ 730	76
77		Alloc. From ECC	2009	8,999	141	141		5	8,718	77
78										78
79										79
80	TOTALS			$ 10,563	$ 454	$ 454	$		$ 9,448	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)	$ 6,175,509	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 134,763	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,623	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (28,140)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,573,435	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 South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Alloc from Extended Care Consulting, LLC				883			5
6								6
7	TOTAL				$ 883 **			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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 3,069 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$		$ 238,933	$		$ 238,933	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			75,529			75,529	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			257,996			257,996	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				238,482		238,482	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					2,524	101,839		104,363	13
14	TOTAL			$		$ 574,982	$ 340,321		$ 915,303	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number South Suburban Rehabilitation Center **#** 0048678 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(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	$ (130,835)	$ (124,082)	1
2	Cash-Patient Deposits	32,828	32,828	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,061,632	1,061,632	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	227,152	227,152	6
7	Other Prepaid Expenses	679	679	7
8	Accounts Receivable (owners or related parties)	(356,201)	(356,201)	8
9	Other(specify): See Attached Schedule	1,062,010	2,796,625	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,897,265	$ 3,638,633	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		3,196,000	14
15	Leasehold Improvements, at Historical Cost	117,003	117,003	15
16	Equipment, at Historical Cost	35,541	2,107,541	16
17	Accumulated Depreciation (book methods)	(32,185)	(3,145,302)	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		1,697,425	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 120,359	$ 4,572,667	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,017,624	$ 8,211,300	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,400,918	$ 1,400,917	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,421	33,421	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,804	131,804	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,139	6,139	31
32	Accrued Real Estate Taxes(Sch.IX-B)	259,957	259,957	32
33	Accrued Interest Payable		12,917	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,278,775	9,795,775	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,111,014	$ 11,640,930	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,341,929	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		2,000,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,341,929	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,111,014	$ 15,982,859	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,093,390)	$ (7,771,559)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,017,624	$ 8,211,300	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,372,090)	1
2	Restatements (describe):		2
3	**Real Estate Accrual**	(172,915)	3
4	**Interest Expense**	2,318	4
5	**Prior Period Income**	3,666	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,539,021)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	445,631	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 445,631	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)**	$ (3,093,390)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,713,700	1
2	Discounts and Allowances for all Levels	(2,189,293)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,524,407	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,043,615	6
7	Oxygen	22,067	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,065,682	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	245,037	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,771	20
21	Other Medical Services	3,500	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 254,308	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,232	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,232	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	5,322	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,322	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,868,951	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,207,477	31
32	Health Care	2,785,479	32
33	General Administration	1,593,643	33
	B. Capital Expense		
34	Ownership	779,615	34
	C. Ancillary Expense		
35	Special Cost Centers	915,303	35
36	Provider Participation Fee	141,803	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,423,320	40
41	**Income before Income Taxes (line 30 minus line 40)****	445,631	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 445,631	43

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

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,821	1,945	$ 88,627	$ 45.57	1
2	Assistant Director of Nursing	703	784	27,609	35.22	2
3	Registered Nurses	8,257	9,201	259,238	28.17	3
4	Licensed Practical Nurses	38,171	41,387	1,024,766	24.76	4
5	CNAs & Orderlies	75,776	82,696	753,411	9.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,724	8,515	136,029	15.98	8
9	Activity Director	506	526	7,034	13.37	9
10	Activity Assistants	10,852	11,782	106,388	9.03	10
11	Social Service Workers	5,800	6,292	142,344	22.62	11
12	Dietician	140	148	2,185	14.76	12
13	Food Service Supervisor	2,060	2,295	41,665	18.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,018	5,595	69,116	12.35	15
16	Dishwashers	11,449	12,699	119,913	9.44	16
17	Maintenance Workers	7,184	8,128	133,697	16.45	17
18	Housekeepers	13,094	14,586	152,774	10.47	18
19	Laundry	4,652	5,373	61,292	11.41	19
20	Administrator	1,986	2,243	87,863	39.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,579	7,086	88,470	12.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,700	1,879	28,517	15.18	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,680	2,007	22,457	11.19	33
34	TOTAL (lines 1 - 33)	205,152	225,167	$ 3,353,395 *	$ 14.89	34

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	244	$ 9,740	01-03	35
36	Medical Director	Monthly	17,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,285	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	275	11-03	44
45	Social Service Consultant	22	885	12-03	45
46	Other(specify)				46
47					47
48	See Attached	725	30,706	12-03	48
49	TOTAL (lines 35 - 48)	996	$ 64,391		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nathan Goldman (01/01/ - 09/30)	Administrator	0	$ 56,839
Marc Halpert (10/01-12/31)	Administrator	0	31,024
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,863

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg&Rothblatt	Accounting	$ 25,369
Personnel Planners	Unemployment Consult.	2,327
Ext. Care Consulting	Home Office Expenses	142,955
Ext. Care Clinical	Home Office Expenses	43,112
ECC - AIS Assessment	MDS Training	1,933
Paycor	Payroll Processing	13,414
eHealth Data Solutions	MDS Software	2,385
Medifax	Software	450
Blymass	Tax Credits	4,231
Extended Care Consult. LLC	Other Professional Fees	8,400
Pinnacle Consulting	Customer Satisfaction Survey	2,222
See Supplemetal Schedule		48,462
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 295,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,806
Unemployment Compensation Insurance	142,811
FICA Taxes	252,706
Employee Health Insurance	90,208
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	
Pension Expenses	12,032
Other Employee Welfare	12,993
Holiday Expenses	2,785
Drug Testing Kits	534
TOTAL (agree to Schedule V, line 22, col.8)	$ 545,875

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	11,731
Health Care Worker Background Check	
(Indicate # of checks performed 366)	5,049
Patient Background Checks	
Dues & Subscription	2,579
Licenses & Fees	2,108
Alloc from Ext Care Consult.	2,306
Alloc from Ext Care Clinical	129
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,892

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,045
Inservice Expenses	4,809
Alloc from Ext Care Consult	113
Alloc from Ext Care Clinical	1,036
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,003

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,556** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **141,803**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.