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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0048678

Facility Name: South Suburban Rehabilitation Center, Llc Ctr

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: 04/01/07

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 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,794	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	94,794	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	41,173	2,781	11,546	55,500	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,173	2,781	11,546	55,500	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.55%

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 1/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 259 and days of care provided 11,365

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: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	318,052	89,716	24,517	432,285		432,285	10,996	443,281			1
2	Food Purchase		322,879		322,879		322,879	391	323,270			2
3	Housekeeping	266,969	96,653	1,969	365,591		365,591	693	366,284			3
4	Laundry	80,419	39,072		119,491		119,491		119,491			4
5	Heat and Other Utilities			193,409	193,409		193,409	1,002	194,411			5
6	Maintenance	113,029		177,503	290,532		290,532	4,959	295,491			6
7	Other (specify):*							4,412	4,412			7
8	TOTAL General Services	778,469	548,320	397,398	1,724,187		1,724,187	22,453	1,746,640			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,301,099	253,378	66,765	3,621,242		3,621,242	63,527	3,684,769			10
10a	Therapy	165,874			165,874		165,874		165,874			10a
11	Activities	178,589	27,756		206,345		206,345		206,345			11
12	Social Services	177,334	1,752	250	179,336		179,336	26,041	205,377			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							15,392	15,392			15
16	TOTAL Health Care and Programs	3,822,896	282,886	103,015	4,208,797		4,208,797	104,960	4,313,757			16
	C. General Administration											
17	Administrative	138,472			138,472		138,472	100,293	238,765			17
18	Directors Fees											18
19	Professional Services			659,337	659,337	(25,185)	634,152	(429,282)	204,870			19
20	Dues, Fees, Subscriptions & Promotions			55,607	55,607		55,607	(11,348)	44,259			20
21	Clerical & General Office Expenses	126,268	41,700	347,220	515,188		515,188	(107,692)	407,496			21
22	Employee Benefits & Payroll Taxes			894,313	894,313		894,313	(15,384)	878,929			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,499	6,499		6,499	2,005	8,504			24
25	Other Admin. Staff Transportation			1,895	1,895		1,895	956	2,851			25
26	Insurance-Prop.Liab.Malpractice			272,360	272,360		272,360	1,784	274,144			26
27	Other (specify):*							40,650	40,650			27
28	TOTAL General Administration	264,740	41,700	2,237,231	2,543,671	(25,185)	2,518,486	(418,018)	2,100,468			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,866,105	872,906	2,737,644	8,476,655	(25,185)	8,451,470	(290,605)	8,160,865			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, Llc Ctr #0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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			53,500	53,500		53,500	126,383	179,883			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,590	110,590		110,590	200,178	310,768			32
33	Real Estate Taxes			519,605	519,605	25,185	544,790	640	545,430			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles			2,363	2,363		2,363	1,235	3,598			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,046,058	1,046,058	25,185	1,071,243	(31,564)	1,039,679			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		672,365	1,044,833	1,717,198		1,717,198	(6,256)	1,710,942			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			410,018	410,018		410,018		410,018			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		672,365	1,454,851	2,127,216		2,127,216	(6,256)	2,120,960			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,866,105	1,545,271	5,238,553	11,649,929		11,649,929	(328,425)	11,321,504			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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	373	30		9
10	Interest and Other Investment Income	(10,295)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(162)	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	(15,925)	21		18
19	Entertainment				19
20	Contributions	(275)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,000)	21		24
25	Fund Raising, Advertising and Promotional	(15,126)	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	(203,166)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (464,576)		$	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)	136,151		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 136,151		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (328,425)		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

STATE OF ILLINOIS

South Suburban Rehabilitation Center, Llc Ctr

ID# 0048678

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (5,705)	06	1
2	Jury Duty	(52)	10	2
3	Theft Loss	(521)	21	3
4	Additonal R&M	1,527	06	4
5	Collection Expense	(6,297)	21	5
6	Bldg. Co. - Amortization	(156,693)	36	6
7	Bldg. Co. - Bank Charge	(317)	21	7
8	Bldg. Co. - Filling Fee	(250)	20	8
9	Non-Allowable Legal	(24,836)	19	9
10	Patient Clothing	(1,394)	10	10
11	Other Income	(132)	21	11
12	Collections	(434)	21	12
13	Annual Report	(250)	20	13
14	Late Fee - Real Estate Tax	(2,539)	33	14
15	Prior Period Adjustment - Employee Benefits	(5,274)	22	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**	(203,166)		49

South Suburban Rehabilitation Center, Llc Ctr

ID# 0048678

Report Period Beginning: 01/01/12

Ending: 12/31/12

	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, Llc Ctr # 0048678 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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			289		11,336	(629)						10,996	1
2	Food Purchase	(162)		553									391	2
3	Housekeeping			552		141							693	3
4	Laundry													4
5	Heat and Other Utilities			799		203							1,002	5
6	Maintenance	(4,178)		3,163	5,911	63							4,959	6
7	Other (specify):*				2,534	1,878							4,412	7
8	**TOTAL General Services**	(4,340)		5,356	8,445	13,621	(629)						22,453	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,446)				64,988	(15)						63,527	10
10a	Therapy													10a
11	Activities													11
12	Social Services					26,041							26,041	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					15,392							15,392	15
16	**TOTAL Health Care and Programs**	(1,446)				106,421	(15)						104,960	16
	C. General Administration													
17	Administrative			3,417	16,003	80,873							100,293	17
18	Directors Fees													18
19	Professional Services	(24,836)		(271,409)		(133,037)							(429,282)	19
20	Fees, Subscriptions & Promotions	(15,901)	250	4,190		113							(11,348)	20
21	Clerical & General Office Expenses	(243,625)	317	14,302	113,813	7,501							(107,692)	21
22	Employee Benefits & Payroll Taxes	(5,274)			(9,797)	(313)							(15,384)	22
23	Inservice Training & Education													23
24	Travel and Seminar			257		1,748							2,005	24
25	Other Admin. Staff Transportation			956									956	25
26	Insurance-Prop.Liab.Malpractice			1,129		655							1,784	26
27	Other (specify):*				26,427	14,223							40,650	27
28	**TOTAL General Administration**	(289,636)	567	(247,158)	146,446	(28,237)							(418,018)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(295,422)	567	(241,802)	154,891	91,805	(644)						(290,605)	29

STATE OF ILLINOIS

Summary B

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

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	373	116,218	8,032		1,760							126,383	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(10,295)	172,458	4,995		33,020							200,178	32
33	Real Estate Taxes	(2,539)		2,534		645							640	33
34	Rent-Facility & Grounds		(360,000)										(360,000)	34
35	Rent-Equipment & Vehicles			1,235									1,235	35
36	Other (specify):*	(156,693)	156,693											36
37	**TOTAL Ownership**	(169,154)	85,369	16,796		35,425							(31,564)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(4,396)	(1,822)		(38)			(6,256)	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**						(4,396)	(1,822)		(38)			(6,256)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(464,576)	85,936	(225,006)	154,891	127,230	(5,040)	(1,822)		(38)			(328,425)	45

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

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 360,000	Homewood Mercy Property, LLC.	100.00%	$	$ (360,000)	1
2	V	33	Rent - RE Taxes	519,605	Homewood Mercy Property, LLC.	100.00%		(519,605)	2
3	V	32	Interest	73,210	Homewood Mercy Property, LLC.	100.00%	245,668	172,458	3
4	V	20	Filing Fee		Homewood Mercy Property, LLC.	100.00%	250	250	4
5	V	21	Bank Charge		Homewood Mercy Property, LLC.	100.00%	317	317	5
6	V	30	Depreciation		Homewood Mercy Property, LLC.	100.00%	116,218	116,218	6
7	V	36	Amortization - Goodwill		Homewood Mercy Property, LLC.	100.00%	153,333	153,333	7
8	V	36	Amortization - Loan Fees		Homewood Mercy Property, LLC.	100.00%	3,360	3,360	8
9	V	33	Real Estate Tax Expense		Homewood Mercy Property, LLC.	100.00%	519,605	519,605	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 952,815			$ 1,038,751	$ * 85,936	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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%	$ 289	$ 289	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	553	553	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	552	552	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	799	799	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,163	3,163	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,417	3,417	20
21	V	19	Professional Fees	276,240	Extended Care Consulting, LLC	100.00%	4,831	(271,409)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	4,190	4,190	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	14,302	14,302	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	257	257	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	956	956	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,129	1,129	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	8,032	8,032	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,995	4,995	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,534	2,534	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,235	1,235	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 276,240			$ 51,234	$ * (225,006)	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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%	7,393	$ 7,393	15
16	V	06	Maintenance (Direct)	10,548	Extended Care Consulting, LLC	100.00%	9,066	(1,482)	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,358	1,358	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,176	1,176	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	16,003	16,003	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	112,332	112,332	22
23	V	21	Office and Clerical (Direct)	20,483	Extended Care Consulting, LLC	100.00%	21,964	1,481	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,579	23,579	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,848	2,848	25
26	V	22	Employee Benefits	9,797	Extended Care Consulting, LLC	100.00%		(9,797)	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			$ 40,828			$ 195,719	$ * 154,891	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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%	$ 141	$ 141	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	203	203	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	63	63	17
18	V	19	Professional Fees	136,056	Extended Care Clinical, LLC	100.00%	3,019	(133,037)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	113	113	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,509	2,509	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,748	1,748	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	655	655	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,760	1,760	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	33,020	33,020	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	645	645	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	11,336	11,336	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,878	1,878	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	64,988	64,988	28
29	V								29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	26,041	26,041	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	15,079	15,079	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	80,873	80,873	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,992	4,992	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	14,223	14,223	34
35	V	10	Nursing / Medical Record Salary	2,420	Extended Care Clinical, LLC	100.00%	2,420		35
36	V	12	Social Service / Admission Salary	250	Extended Care Clinical, LLC	100.00%	250		36
37	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	313	313	37
38	V	22	Employee Benefits	313	Extended Care Clinical, LLC	100.00%		(313)	38
39	Total			$ 139,039			$ 266,269	$ * 127,230	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 2,246	Care Centers Health Systems, Inc.	100.00%	$ 1,617	$ (629)	15
16	V	10	Nursing Supplies	55	Care Centers Health Systems, Inc.	100.00%	40	(15)	16
17	V	39	Ancillary Expense	15,700	Care Centers Health Systems, Inc.	100.00%	11,304	(4,396)	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			$ 18,001			$ 12,961	$ * (5,040)	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 1,044,833	Tri Care Rehab	100.00%	$ 1,043,011	$ (1,822)	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			$ 1,044,833			$ 1,043,011	$ * (1,822)	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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%	$ 102,704	$ 102,704	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	102,704	CCS Employee Benefits Group	100.00%		(102,704)	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			$ 102,704			$ 102,704	$ *	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Ancillary Expense	4,288	Reliable Medical of the Midwest, LLC	100.00%	4,250	$ (38)	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			$ 4,288			$ 4,250	$ * (38)	39

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	HOMEWOOD MERCY PROPERT		BUILDING CO.	1
2	GALE ROTHNER	49.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			CHATEAU NURSING AND REHABILITATION CENTER, LLC	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	TRICARE REHAB	HILLSIDE	THERAPY	6
7			DEVON GABLES REHABILITATION CENTER	ARIZONA	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	7
8			DYER NURSING & REHAB	DYER, IN	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	8
9			FOOTHILLS REHABILITATION CENTER LLC	ARIZONA				9
10			GOLDEN PLAINES REHABILITATION CENTER	KANSAS				10
11			GRASMERE PLACE, LLC	CHICAGO				11
12			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				12
13			HOMESTEAD NURSING & REAHB	LINCOLN, NE				13
14			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				14
15			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				15
16			LANCASTER MANOR	LINCOLN, NE				16
17			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				17
18			MCKINLEY HEALTH CARE CENTER	CANTON, OH				18
19			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				19
20			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				20
21			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				21
22			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				22
23			RAINBOW BEACH QOC, L.L.C.	CHICAGO				23
24			SEBOS NURSING & REHAB	HOLBART, IN				24
25			SHEFFIELD MANOR	DYER, IN				25
26			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				26
27			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				29
30			WHEATON CARE CENTER	WHEATON				30

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

VII. RELATED PARTIES

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

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

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	N/A	See Attached	0.88	2.20%	Alloc. Salary	$ 1,611	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.66	6.65%	Al Sal/Al Fee	12,742	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 14,353		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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	1,364,178	31	$ 7,101	$	55,500	$ 289	1
2	02	Food	Patient Days	1,364,178	31	13,586		55,500	553	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		55,500	552	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		55,500	799	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		55,500	3,163	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		55,500	3,417	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		55,500	4,831	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		55,500	4,190	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		55,500	14,302	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		55,500	257	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		55,500	956	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		55,500	1,129	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		55,500	8,032	13
14	32	Interest	Patient Days	1,364,178	31	122,765		55,500	4,995	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		55,500	2,534	15
16	34	Rent - Building	Patient Days	1,364,178	31			55,500		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		55,500	1,235	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 51,234	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,364,178	31	181,713	181,713	55,500	7,393	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754		9,066	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		55,500	1,358	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137			1,176	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	55,500	16,003	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	55,500	112,332	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		21,964	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		55,500	23,579	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			2,848	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,679,511	$ 3,961,379		$ 195,719	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	611,520	14	$ 1,549	$	55,500	$ 141	1
2	05	Utilities	Patient Days	611,520	14	2,241		55,500	203	2
3	06	Maintenance	Patient Days	611,520	14	691		55,500	63	3
4	19	Professional Fees	Patient Days	611,520	14	33,266		55,500	3,019	4
5	20	Dues and Subscriptions	Patient Days	611,520	14	1,249		55,500	113	5
6	21	Office & Clerical	Patient Days	611,520	14	27,644		55,500	2,509	6
7	24	Travel and Seminar	Patient Days	611,520	14	19,257		55,500	1,748	7
8	26	Insurance	Patient Days	611,520	14	7,216		55,500	655	8
9	30	Depreciation	Patient Days	611,520	14	19,393		55,500	1,760	9
10	32	Interest	Patient Days	611,520	14	363,826		55,500	33,020	10
11	33	Real Estate Taxes	Patient Days	611,520	14	7,106		55,500	645	11
12	01	Dietary Salary	Patient Days	611,520	14	124,907	124,907	55,500	11,336	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	611,520	14	20,691		55,500	1,878	13
14	10	Nursing Salary	Patient Days	611,520	14	716,058	716,058	55,500	64,988	14
15										15
16	12	Social Service Salary	Patient Days	611,520		286,925	286,925	55,500	26,041	16
17	15	Emp. Ben. - Healthcare	Patient Days	611,520		166,142		55,500	15,079	17
18	17	Administration Salary	Patient Days	611,520		891,091	891,091	55,500	80,873	18
19	21	Office Salary	Patient Days	611,520		55,009	55,009	55,500	4,992	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	611,520		156,720		55,500	14,223	20
21	10	Nursing / Medical Record Salary	Direct Allocation			10,300	10,300		2,420	21
22	12	Social Service / Admission Salary	Direct Allocation			6,057	6,057		250	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			2,077			313	23
24										24
25	TOTALS					$ 2,919,416	$ 2,090,347		$ 266,269	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 1,617	1
2	10	Nursing Supplies	Direct Allocation						40	2
3	39	Ancillary Expense	Direct Allocation						11,304	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					$	$		$ 12,961	25

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

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			$	$		$ 1,043,011	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					$	$		$ 1,043,011	25

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

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			$	$		$ 102,704	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					$	$		$ 102,704	25

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

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	39	Ancillary Expense	Direct Allocation						4,250	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					$	$		$ 4,250	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc C1 # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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				$	$			$ 47,198	1
2	National City / Ridgeland		X	Mortgage Loan				2,584,803			120,782	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	HFG		X	Loan				1,579,885			124,886	6
7	Lake Forest		X								58,797	7
8	See Supplemental Schedule										42,609	8
9	TOTAL Facility Related						$	$ 4,164,688			$ 394,273	9
	B. Non-Facility Related*											
10	Interest Income		X								(10,295)	10
11	Interest Income - Bldg Co.		X								(73,210)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (83,505)	14
15	TOTALS (line 9+line14)						$	$ 4,164,688			$ 310,767	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, Llc C1 # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Cole Taylor Bank		X				$	$			$ 4,523	8
9	DIAWA		X								71	9
10	Alloc from Ext Care Cnsult		X								4,995	10
11	Alloc from Ext Care Clinical		X								33,020	11
12												12
13												13
14	TOTAL Working Capital										42,609	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, Llc Ctr **#** 0048678 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 323,057	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.)		$ 412,995	2
3. Under or (over) accrual (line 2 minus line 1).		$ 89,938	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 430,307	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.**		$ 25,185	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.		$ 545,430	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	172,220	8
	2008	233,674	9
	2009	247,578	10
	2010	307,674	11
	2011	409,816	12

2012 Accrual = 409,816 x 1.05 = 430,307

Allocated from ECC Consult: $2,534

Allocated from ECC Clinical: $645

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center, Llc Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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	$ 409,815.84	$ 409,815.84
2.	See Attached	Allocated from 2201 Main, LLC	$ 127,119.67	$ 2,525.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 536,935.51	$ 412,341.20

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center, Llc Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

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	$ 228,875	1
2	Allocated from Extended Care Consult. & Clinical			16,290	2
3	TOTALS			$ 245,165	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	259		2007	1976	$ 4,495,348	$ 116,218	35	$ 128,439	$ 12,221	$ 585,009	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	32,306		20	2,956	2,956	15,898	9
10	Various			2008	41,532		20	2,354	2,354	11,471	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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54									54
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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)								67
68	Related Party Allocations (Pages 12H & 12I)		66,049	4,490		4,490		40,254	68
69	Financial Statement Depreciation			53,500			(53,500)		69
70	TOTAL (lines 4 thru 69)		$ 4,635,235	$ 174,208		$ 138,239	$ (35,969)	$ 652,631	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,635,235	$ 174,208		$ 138,239	$ (35,969)	$ 652,631	1
2	Smoke Dampers	2009	26,600		20	1,330	1,330	5,209	2
3	Security System For Front Door	2009	2,644		20	529	529	1,630	3
4	Sidewalk	2010	3,565		20	238	238	634	4
5	4 Locks	2010	3,250		20	650	650	1,679	5
6	Walk In Freezer	2010	5,100		20	1,020	1,020	2,550	6
7	Shower Renovation	2010	14,701		20	735	735	1,654	7
8	Ceramic Tile In Kitchen	2010	5,550		20	278	278	601	8
9	Roof Repair - East & West Sides	2010	4,200		20	210	210	438	9
10	Install New Sec System	2011	4,748		20	950	950	1,820	10
11	Bracelets & Alarm W/ 2 Keypads	2011	7,617		20	1,523	1,523	2,793	11
12	Decorating Project	2011	2,936		20	147	147	257	12
13	Install 5 Condensing Units	2011	61,900		20	3,095	3,095	5,416	13
14	Imperial Water Booster	2011	2,606		20	521	521	912	14
15	Steel Door & Dead Bolt Lock	2011	2,664		20	133	133	222	15
16	Shower Renovation	2011	6,500		20	325	325	460	16
17	Swimming Pool Renovation	2011	14,200		20	710	710	947	17
18	Heat Exchanger	2011	2,583		20	129	129	161	18
19	Wallpaper	2011	15,248		20	1,525	1,525	1,652	19
20	Privacy Curtains	2011	4,429		20	886	886	960	20
21	Cubicle Curtains	2011	2,983		20	597	597	646	21
22	Accutech Bracelets	2011	3,274		20	655	655	709	22
23	Painting	2011	4,007		20	200	200	367	23
24	Painting	2011	12,177		20	609	609	1,065	24
25	Install New Detector Edge & Fan	2011	3,990		20	200	200	249	25
26	Cubicle Curtains	2012	10,138		20	2,028	2,028	2,028	26
27	Landscaping- Plant Material, Install Patio Block, Remove And Dis	2012	6,695		20	298	298	298	27
28	New Duro Last Roofing System	2012	105,500		20	3,956	3,956	3,956	28
29	Provide And Install 2 Lenard Mixing Valves	2012	10,600		20	177	177	177	29
30	Install Circulating Fans In Radiator Cabinet And Install Needed P	2012	3,033		20	152	152	152	30
31	Installed Compressors, Driers, Freon, Vac Pump On Air Conditio	2012	2,673		20	134	134	134	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,991,344	$ 174,208		$ 162,175	$ (12,033)	$ 692,407	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,991,344	$ 174,208		$ 162,175	$ (12,033)	$ 692,407	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,991,344	$ 174,208		$ 162,175	$ (12,033)	$ 692,407	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,991,344	$ 174,208		$ 162,175	$ (12,033)	$ 692,407	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,991,344	$ 174,208		$ 162,175	$ (12,033)	$ 692,407	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,991,344	$ 174,208		$ 162,175	$ (12,033)	$ 692,407	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,991,344	$ 174,208		$ 162,175	$ (12,033)	$ 692,407	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									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
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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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company 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
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	4,555	117	39	117		1,202	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	17,894	459	39	459		4,722	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2002	14,781	1,351	20	1,351		12,171	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2003	17,419	1,592	20	1,592		14,343	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2005	865	92	20	92		588	12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2009	156	8	20	8		31	13
14									14
15	Allocated from Extended Care Consulting, LLC	2007	187	9	20	9		56	15
16	Allocated from Extended Care Consulting, LLC	2009	112	6	20	6		22	16
17	Allocated from Extended Care Consulting, LLC	2010	1,098	55	20	55		165	17
18	Allocated from Extended Care Consulting, LLC	2011	395	20	20	20		40	18
19	Allocated from Extended Care Consulting, LLC	2012	130	7	20	7		7	19
20									20
21									21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	3,763	344	20	344		3,098	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	4,434	405	20	405		3,651	23
24	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	220	23	20	23		150	24
25	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	40	2	20	2		8	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party 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
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 66,049	$ 4,490		$ 4,490	$	$ 40,254	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 82,715	$ 3,300	$ 9,042	$ 5,742	10	$ 61,768	71
72	Current Year Purchases	49,979		6,664	6,664	10	6,664	72
73	Fully Depreciated Assets	1,259,693				10	1,259,693	73
74								74
75	TOTALS	$ 1,392,387	$ 3,300	$ 15,706	$ 12,406		$ 1,328,125	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Cl	2012	$ 4,663	$ 743	$ 743	$	5	$ 446	76
77		Allocated from Extended Care Cc	2012	6,305	1,261	1,261		5	6,305	77
78										78
79										79
80	TOTALS			$ 10,968	$ 2,004	$ 2,004	$		$ 6,751	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)	$ 6,639,864	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,512	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,885	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 373	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,027,283	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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 3,598 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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 453,220	$		$ 453,220	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			119,993			119,993	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			471,620			471,620	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				455,601		455,601	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						216,764		216,764	13
14	TOTAL			$		$ 1,044,833	$ 672,365		$ 1,717,198	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, Llc Ctr **#** 0048678 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/12 **(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	$ 34,490	$ 68,464	1
2	Cash-Patient Deposits	30,110	30,110	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,783,358	1,783,358	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	354,902	354,902	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)	(190,000)	(190,000)	8
9	Other(specify): See Attached Schedule	2,294,796	4,948,223	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,309,646	$ 6,997,047	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			14
15	Leasehold Improvements, at Historical Cost	334,572	3,530,572	15
16	Equipment, at Historical Cost	147,003	2,219,003	16
17	Accumulated Depreciation (book methods)	(112,797)	(3,458,350)	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		616,974	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 368,778	$ 3,508,199	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,678,424	$ 10,505,246	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,751,567	$ 4,751,569	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,239	66,239	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	244,649	244,649	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,185	13,185	31
32	Accrued Real Estate Taxes(Sch.IX-B)	430,307	430,307	32
33	Accrued Interest Payable	189,870	199,392	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	417,297	6,939,072	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,113,114	$ 12,644,413	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,164,688	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,164,688	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,113,114	$ 16,809,101	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,434,690)	$ (6,303,855)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,678,424	$ 10,505,246	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,140,294)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,140,291)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	865,601	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	(160,000)	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)**	$ 705,601	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,434,690)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,365,947	1
2	Discounts and Allowances for all Levels	(4,946,286)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,419,661	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,427,938	6
7	Oxygen	25,081	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,453,019	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	480,904	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	61,744	19
20	Radiology and X-Ray	4,080	20
21	Other Medical Services	85,643	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 632,371	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,295	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,295	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	184	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 184	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,515,530	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,724,187	31
32	Health Care	4,208,797	32
33	General Administration	2,543,671	33
	B. Capital Expense		
34	Ownership	1,046,058	34
	C. Ancillary Expense		
35	Special Cost Centers	1,717,198	35
36	Provider Participation Fee	410,018	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,649,929	40
41	**Income before Income Taxes (line 30 minus line 40)****	865,601	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 865,601	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,924,964	44
45	Private Pay - Net Inpatient Revenue	468,700	45
46	Medicare - Net Inpatient Revenue	691,915	46
47	Other-(specify) Hospice	341,888	47
48	Other-(specify) Insurance	(7,806)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,419,661	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,921	2,108	$ 97,474	$ 46.24	1
2	Assistant Director of Nursing	1,908	2,070	77,775	37.57	2
3	Registered Nurses	19,311	20,608	632,673	30.70	3
4	Licensed Practical Nurses	46,026	48,809	1,302,267	26.68	4
5	CNAs & Orderlies	105,544	115,612	1,122,643	9.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,899	12,169	165,874	13.63	8
9	Activity Director	1,971	2,153	35,197	16.35	9
10	Activity Assistants	14,226	15,765	143,392	9.10	10
11	Social Service Workers	7,106	7,831	177,334	22.65	11
12	Dietician	837	889	14,648	16.48	12
13	Food Service Supervisor	2,570	2,856	54,027	18.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,683	7,601	96,148	12.65	15
16	Dishwashers	14,347	15,997	153,229	9.58	16
17	Maintenance Workers	5,971	6,703	113,029	16.86	17
18	Housekeepers	22,421	24,892	266,969	10.73	18
19	Laundry	7,734	8,403	80,419	9.57	19
20	Administrator	1,869	1,952	96,930	49.66	20
21	Assistant Administrator	1,691	1,931	41,542	21.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,921	8,556	126,268	14.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,409	2,678	36,615	13.67	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,909	2,163	31,652	14.63	33
34	TOTAL (lines 1 - 33)	285,274	311,746	$ 4,866,105 *	$ 15.61	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	613	$ 24,517	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,439	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatrist	Monthly	790	10-03	47
48	See Attached		2,670		48
49	TOTAL (lines 35 - 48)	613	$ 74,416		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	1,771	53,116	10-03	52
53	TOTAL (lines 50 - 52)	1,771	$ 53,116		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, Llc Ctr # 0048678 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nikki Dinsmore	Administrator	0.00%	$ 2,035
Christina Gardiner	Administrator	0.00%	22,341
Marc Halpert	Administrator	0.00%	72,555
Shicole Ashford	Assist. Admin	0.00%	10,029
Elizabeth Daniels	Assist. Admin	0.00%	22,210
Stephanie Mohr	Assist. Admin	0.00%	9,303
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 138,472

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 96,479
Western Litigation	Risk Management	15,107
Blymas Inc.	Tax Credit Services	8,021
Coms Interactive	Clinical Assessment	7,200
Hamlin & Burton	Liability Management	2,518
Pinnacle Quality Insight	Customer Satisf. Survey	1,992
Prospect Resources	Energy Consultant	650
Skidelsky & Associates	RE Assesment	25,185
DAIWA	LOC	21,379
Paycor	Payroll Processing	21,495
Pro Payroll Solutions	Payroll Processing	6,308
See Supplemetal Schedule		453,003
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 659,337

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 187,129
Unemployment Compensation Insurance	201,726
FICA Taxes	368,307
Employee Health Insurance	78,968
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	9,748
Pension Expense	15,804
Other Employee Welfare	13,874
Holiday Expense	3,373
TOTAL (agree to Schedule V, line 22, col.8)	$ 878,929

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	1,031
Health Care Worker Background Check	3,962
(Indicate # of checks performed 159)	
Patient Background Checks	
Dues and Subscriptions	26,540
Licenses and Fees	6,433
Allocated from ECC Consulting	4,190
Allocated from ECC Clinical	113
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,259

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,500
Allocated from ECC Consulting	257
Allocated from ECC Clinical	1,748
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,505

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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, Llc Ctr # 0048678 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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? **Yes**
If YES, give association name and amount. **IL Council on LTC $24,605**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **45,544** 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. $ **410,018**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) 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.