FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0048678

Facility Name: South Suburban Rehab Center

Address: 19000 S Halsted St (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: 4/1/2007

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,535	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	49,965	2,995	4,786	57,746	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,965	2,995	4,786	57,746	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.08%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2007 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 4,045

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	313,739	151,508	37,629	502,876		502,876	10,777	513,653			1
2	Food Purchase		342,047		342,047		342,047	333	342,380			2
3	Housekeeping	320,885	64,786		385,671		385,671	1,486	387,157			3
4	Laundry	68,047	29,048		97,095		97,095		97,095			4
5	Heat and Other Utilities			264,046	264,046		264,046	2,234	266,280			5
6	Maintenance	139,435		270,299	409,734		409,734	17,674	427,408			6
7	Other (specify):*							8,891	8,891			7
8	**TOTAL General Services**	842,106	587,389	571,974	2,001,469		2,001,469	41,395	2,042,864			8
	B. Health Care and Programs											
9	Medical Director			57,050	57,050		57,050		57,050			9
10	Nursing and Medical Records	3,700,959	353,955	27,840	4,082,754		4,082,754	48,499	4,131,253			10
10a	Therapy	275,392			275,392		275,392		275,392			10a
11	Activities	249,542	15,830		265,372		265,372		265,372			11
12	Social Services	244,289	6,308		250,597		250,597	30,204	280,801			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							10,358	10,358			15
16	**TOTAL Health Care and Programs**	4,470,182	376,093	84,890	4,931,165		4,931,165	89,061	5,020,226			16
	C. General Administration											
17	Administrative	198,351			198,351		198,351	106,113	304,464			17
18	Directors Fees											18
19	Professional Services			707,893	707,893	(25,721)	682,172	(516,494)	165,678			19
20	Dues, Fees, Subscriptions & Promotions			98,522	98,522		98,522	(50,815)	47,707			20
21	Clerical & General Office Expenses	111,281	56,794	608,445	776,520		776,520	(325,543)	450,977			21
22	Employee Benefits & Payroll Taxes			1,168,941	1,168,941		1,168,941	(26,570)	1,142,371			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,322	5,322		5,322	1,765	7,087			24
25	Other Admin. Staff Transportation			6,407	6,407		6,407	1,640	8,047			25
26	Insurance-Prop.Liab.Malpractice			351,372	351,372		351,372	2,328	353,700			26
27	Other (specify):*							40,751	40,751			27
28	**TOTAL General Administration**	309,632	56,794	2,946,902	3,313,328	(25,721)	3,287,607	(766,825)	2,520,782			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,621,920	1,020,276	3,603,766	10,245,962	(25,721)	10,220,241	(636,369)	9,583,872			29

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

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

Facility Name & ID Number South Suburban Rehab Center #0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			150,312	150,312		150,312	251,000	401,312			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,441	70,441		70,441	421,587	492,028			32
33	Real Estate Taxes			552,723	552,723	25,721	578,444	5,901	584,345			33
34	Rent-Facility & Grounds			780,000	780,000		780,000	(780,000)				34
35	Rent-Equipment & Vehicles			5,121	5,121		5,121	979	6,100			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,558,597	1,558,597	25,721	1,584,318	(100,533)	1,483,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		307,815	708,707	1,016,522		1,016,522	(1,181)	1,015,341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			464,091	464,091		464,091		464,091			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		307,815	1,172,798	1,480,613		1,480,613	(1,181)	1,479,432			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,621,920	1,328,091	6,335,161	13,285,172		13,285,172	(738,083)	12,547,089			45

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	121,458	30		9
10	Interest and Other Investment Income	(1,156)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(176)	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	(1,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(457,590)	21		24
25	Fund Raising, Advertising and Promotional	(44,276)	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	(266,521)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (649,261)		$	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)	(88,822)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (88,822)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (738,083)		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

South Suburban Rehab Center

ID# 0048678

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (2,967)	10	1
2	Theft Loss	(3,379)	21	2
3	Collection Expense	(8,368)	21	3
4	Annual Report	(250)	20	4
5	Lobbying	(1,410)	21	5
6	PAC Dues	(7,333)	20	6
7	Non-Allowable Legal	(38,706)	19	7
8	Bldg. Co. - Filing Fee	(250)	20	8
9	Bldg. Co. - Management Fees	(10,500)	17	9
10	Bldg. Co. - Legal Fees	(566)	19	10
11	Bldg. Co - Amortization	(175,564)	31	11
12	Chambers of Commerce Dues	(370)	20	12
13	Prior Year Expense	(16,858)	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(266,521)		49

South Suburban Rehab Center

ID# 0048678

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Suburban Rehab Center # 0048678 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			191		10,586							10,777	1
2	Food Purchase	(176)		509									333	2
3	Housekeeping			1,342		144							1,486	3
4	Laundry													4
5	Heat and Other Utilities			2,034		200							2,234	5
6	Maintenance			5,854	11,671	149							17,674	6
7	Other (specify):*				7,553	1,338							8,891	7
8	**TOTAL General Services**	(176)		9,930	19,224	12,417							41,395	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,967)				51,769			(303)				48,499	10
10a	Therapy													10a
11	Activities													11
12	Social Services					30,204							30,204	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,358							10,358	15
16	**TOTAL Health Care and Programs**	(2,967)				92,331			(303)				89,061	16
	C. General Administration													
17	Administrative	(10,500)	10,500	3,658	20,466	81,989							106,113	17
18	Directors Fees													18
19	Professional Services	(39,272)	566	(357,280)		(120,508)							(516,494)	19
20	Fees, Subscriptions & Promotions	(52,479)	250	1,199		215							(50,815)	20
21	Clerical & General Office Expenses	(488,605)		14,973	122,579	25,510							(325,543)	21
22	Employee Benefits & Payroll Taxes				(26,570)								(26,570)	22
23	Inservice Training & Education													23
24	Travel and Seminar			412		1,353							1,765	24
25	Other Admin. Staff Transportation			1,640									1,640	25
26	Insurance-Prop.Liab.Malpractice			1,673		655							2,328	26
27	Other (specify):*				27,400	13,351							40,751	27
28	**TOTAL General Administration**	(590,856)	11,316	(333,725)	143,875	2,565							(766,825)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(593,999)	11,316	(323,795)	163,099	107,313			(303)				(636,369)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **South Suburban Rehab Center** **# 0048678** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	121,458	126,011	2,652		879							251,000	30
31	Amortization of Pre-Op. & Org.	(175,564)	175,564											31
32	Interest	(1,156)	411,824	10,668		251							421,587	32
33	Real Estate Taxes			5,347		554							5,901	33
34	Rent-Facility & Grounds		(780,000)										(780,000)	34
35	Rent-Equipment & Vehicles			979									979	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(55,262)	(66,601)	19,646		1,684							(100,533)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(1,181)				(1,181)	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**								(1,181)				(1,181)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(649,261)	(55,285)	(304,149)	163,099	108,997			(1,484)				(738,083)	45

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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	$ 780,000	Homewood Mercy Property, LLC	100.00%	$	$ (780,000)	1
2	V	30	Depreciation		Homewood Mercy Property, LLC	100.00%	126,011	126,011	2
3	V	20	Filing Fee		Homewood Mercy Property, LLC	100.00%	250	250	3
4	V	19	Legal Fees		Homewood Mercy Property, LLC	100.00%	566	566	4
5	V	31	Amortization		Homewood Mercy Property, LLC	100.00%	175,564	175,564	5
6	V	17	Management Fees		Homewood Mercy Property, LLC	100.00%	10,500	10,500	6
7	V	32	Interest Expense - Talmer Bank		Homewood Mercy Property, LLC	100.00%	411,824	411,824	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 780,000			$ 724,715	$ * (55,285)	14

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 191	$ 191	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	509	509	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,342	1,342	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	2,034	2,034	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	5,854	5,854	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,658	3,658	20
21	V	19	Professional Fees	363,744	Extended Care Consulting, LLC	100.00%	6,464	(357,280)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,199	1,199	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	14,973	14,973	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	412	412	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,640	1,640	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,673	1,673	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,652	2,652	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	10,668	10,668	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,347	5,347	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	979	979	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			$ 363,744			$ 59,595	$ * (304,149)	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	11,671	$ 11,671	15
16	V	06	Maintenance (Direct)	55,349	Extended Care Consulting, LLC	100.00%	55,349		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,004	1,004	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	6,549	6,549	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	20,466	20,466	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	122,579	122,579	22
23	V	21	Office and Clerical (Direct)	33,217	Extended Care Consulting, LLC	100.00%	33,217		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	24,556	24,556	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,844	2,844	25
26	V	22	Employee Benefits	26,570	Extended Care Consulting, LLC	100.00%		(26,570)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 115,136			$ 278,235	$ * 163,099	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 144	$ 144	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	200	200	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	149	149	17
18	V	19	Professional Fees	121,248	Extended Care Clinical, LLC	100.00%	740	(120,508)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	215	215	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,833	1,833	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,353	1,353	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	655	655	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	879	879	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	251	251	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	554	554	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	10,586	10,586	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,338	1,338	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	51,769	51,769	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	30,204	30,204	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	10,358	10,358	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	81,989	81,989	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	23,677	23,677	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	13,351	13,351	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,248			$ 230,245	$ * 108,997	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 414,136	Tri Care Rehab	100.00%	$ 414,136	$	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			$ 414,136			$ 414,136	$ *	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 290,608	$ 290,608	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	290,608	CCS Employee Benefits Group	100.00%		(290,608)	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			$ 290,608			$ 290,608	$ *	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 22,929	MAC Rx, LLC	100.00%	$ 22,626	$ (303)	15
16	V	39	Ancillary	89,458	MAC Rx, LLC	100.00%	88,276	(1,181)	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			$ 112,386			$ 110,902	$ * (1,484)	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	HOMEWOOD MERCY PROPERTIES, LLC		BUILDING CO.	1
2	GALE ROTHNER	49.00%	BRIAR PLACE LTD.	INDIAN HEAD PARK	Extended Care Consulting	Evanston	Mgmt / Bookkeeping	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	Extended Care Clinical	Evanston	Clinical	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	Care Centers Building	Evanston	Building Company	4
5			GRASMERE PLACE, LLC	CHICAGO	Vent Lease LLC	Evanston	Ventilator Equipment	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	Tri Care Rehab	Hillside	Therapy	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. Veba	Evanston	Health Insurance	7
8			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	Des Plaines	Pharmacy	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	Reliable Medical Supply	Des Plaines	Medical Supplies	9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24			PARC AT JOLIET	JOLIET				24
25			SPRING CREEK	JOLIET				25
26			ESTATES OF HYDE PARK	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	N/A	See Attached	1.84	4.60%	Alloc. Salary	$ 3,118	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.33	6.05%	Alloc Sal/Mgmt	12,310	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,428		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 Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,326,152	31	$ 4,390	$	57,746	$ 191	1
2	02	Food	Patient Days	1,326,152	31	11,689		57,746	509	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		57,746	1,342	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		57,746	2,034	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		57,746	5,854	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		57,746	3,658	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		57,746	6,464	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		57,746	1,199	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		57,746	14,973	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		57,746	412	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		57,746	1,640	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		57,746	1,673	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		57,746	2,652	13
14	32	Interest	Patient Days	1,326,152	31	244,990		57,746	10,668	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		57,746	5,347	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		57,746	979	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 59,595	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,326,152	31	268,019	268,019	57,746	11,671	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		55,349	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		57,746	1,004	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			6,549	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	57,746	20,466	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	57,746	122,579	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		33,217	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		57,746	24,556	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			2,844	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,964,932	$ 4,280,758		$ 278,235	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	794,254	19	$ 1,974	$	57,746	$ 144	1
2	05	Utilities	Patient Days	794,254	19	2,745		57,746	200	2
3	06	Maintenance	Patient Days	794,254	19	2,053		57,746	149	3
4	19	Professional Fees	Patient Days	794,254	19	10,180		57,746	740	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961		57,746	215	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207		57,746	1,833	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605		57,746	1,353	7
8	26	Insurance	Patient Days	794,254	19	9,008		57,746	655	8
9	30	Depreciation	Patient Days	794,254	19	12,096		57,746	879	9
10	32	Interest	Patient Days	794,254	19	3,455		57,746	251	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615		57,746	554	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	145,601	57,746	10,586	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397		57,746	1,338	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	712,051	57,746	51,769	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	415,434	57,746	30,204	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463		57,746	10,358	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	1,127,702	57,746	81,989	17
18	21	Office Salary	Patient Days	794,254	19	325,657	325,657	57,746	23,677	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638		57,746	13,351	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,166,842	$ 2,726,445		$ 230,245	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: TriCare Rehab
Street Address: 240 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			$	$		$ 414,136	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					$	$		$ 414,136	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 290,608	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					$	$		$ 290,608	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 22,626	1
2	39	Ancillary	Direct Allocation						88,276	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					$	$		$ 110,902	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Talmer Bank		X	Mortgage			$	$ 8,413,795			$ 411,824	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	Line of Credit				3,241,210			66,787	6
7	Lake Forest		X								3,654	7
8	See Supplemental Schedule							80,321			10,919	8
9	TOTAL Facility Related						$	$ 11,735,327			$ 493,184	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,156)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,156)	14
15	TOTALS (line 9+line14)						$	$ 11,735,327			$ 492,028	15

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	ECC-Mattresses		X				$	$ 80,321			$	8
9	Alloc. Ext Care Clinical		X								251	9
10	Alloc. Ext Care Consulting		X								10,668	10
11												11
12												12
13												13
14	TOTAL Working Capital							80,321			10,919	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 Rehab Center # 0048678 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	470,221	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.)	$	504,898	2
3. Under or (over) accrual (line 2 minus line 1).	$	34,677	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	523,947	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.**	$	25,721	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.	$	584,345	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	307,674	8
	2011	409,816	9
	2012	438,945	10
	2013	447,829	11
	2014	498,997	12

2015 Accrual = $498,997 x 1.05 = $523,947

Allocated from Extended Care Clinical $554

Allocated from Extended Care Consulting $5,347

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-05-400-011-0000	Long Term Care Property	$ 498,997.37	$ 498,997.37
2.	See Attached	Allocated from 2201 Main	$ 165,913.23	$ 5,596.43
3.	See Attached	Allocated from Dyer Admin Office	$ 3,814.66	$ 166.11
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 668,725.26	$ 504,759.91

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,542 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	Alloc. From Care Center Building			27,659	2
3	TOTALS			$ 256,534	3

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	259		2007	1976	$ 4,495,349	$ 126,011	35	$ 128,439	$ 2,428	$ 970,326	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	32,656		20	911	911	21,992	9
10	Various			2008	35,282		20	2,042	2,042	16,033	10
11	Various			2009	29,244		20	1,330	1,330	11,843	11
12	Various			2010	36,366		20	2,241	2,241	16,057	12
13	Various			2011	151,861		20	12,204	12,204	55,249	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 Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		116,493	1,572		1,572		84,689	68
69	Financial Statement Depreciation			150,312			(150,312)		69
70	TOTAL (lines 4 thru 69)		$ 4,897,251	$ 277,895		$ 148,738	$ (129,157)	$ 1,176,190	70

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,897,251	$ 277,895		$ 148,738	$ (129,157)	$ 1,176,190	1
2	Cubicle Curtains	2012	10,138		20	2,028	2,028	8,110	2
3	Landscaping	2012	6,695		20	446	446	1,637	3
4	New Duro Last Roofing System	2012	105,500		20	5,275	5,275	19,781	4
5	Provide And Install 2 Lenard Mixing Valves	2012	10,600		20	530	530	1,767	5
6	Install Circulating Fans In Radiator Cabinet And Install Needed F	2012	3,033		20	152	152	607	6
7	Installed Compressors, Driers, Freon, Vac Pump On A/C'S	2012	2,673		20	134	134	468	7
8	Sprinkler Heads - Installed Mac Tee To 4X2	2013	9,780		20	489	489	1,467	8
9	Wires From 120V Ac Output To Each Door	2013	9,000		20	450	450	1,350	9
10	Furn/Inst 2 Door Restrictors,Fire Key Boxes-Elevator,Pit Stop Sw	2013	5,589		20	279	279	838	10
11	Installed Sprinkler In Elevator Pits- 4 " Mac Tee Cut Pipe, 1"Wat	2013	3,390		20	170	170	509	11
12	Installed Bearing With Pump Seal, Coupler, And Body Gasket In	2013	4,177		20	835	835	2,367	12
13	Ceiling Panels	2013	5,508		20	275	275	734	13
14	Installed One Three Pole 70 Ampere Circuit Breaker On First Flo	2013	4,500		20	225	225	600	14
15	Spray Fireproofing	2013	10,690		20	535	535	1,425	15
16	Installed A Ejector Pump In Basement	2013	3,375		20	169	169	408	16
17	Replaced Entire Walkway Concrete On Loading Dock, Repaired F	2013	14,800		20	740	740	1,727	17
18	Replacement Of Fire Alarm System & Devices	2013	11,320		20	2,264	2,264	5,283	18
19	Replaced Smoke Detectors And Duct Detectors On 2Nd Floor	2013	6,430		20	1,286	1,286	3,001	19
20	Installed Flooring On 1St Floor Cooridors, Lounges, Living & Din	2013	118,000		20	23,600	23,600	49,167	20
21	East Side Of Lobby/Basement - Installed Dry System, Piping, Spri	2013	28,000		20	718	718	2,124	21
22	Elevator Machine Room Sprinkler - Smoke/Heat Detectors, Sprinl	2013	7,995		20	205	205	606	22
23	Installed 70 Sprinkler Heads On The 2Nd Floor	2013	4,536		20	116	116	237	23
24	Installed Exit Signs In Pt Room, 410 Hall Exit, Hallways In Basem	2013	3,500		20	90	90	183	24
25	Roof Over 800/500/Middle Flat Roof; Installed 15Yr White Pvs Re	2013	162,164		20	16,216	16,216	47,298	25
26	Installed 6 Drains, 6 Pitch Pans, Flashers, And Flashing Rails On I	2013	66,800		20	3,340	3,340	8,350	26
27	Replaced Broken Gas Line And Installed New Pipe And Fittings	2013	8,175		20	409	409	988	27
28	Ceiling Grid-2Nd Fl/Ceiling Panels/Fire Sprinkler/Sink Base Cabi	2013	16,830		20	842	842	2,104	28
29	Patching & Fire Caulking In Various Locations	2013	11,123		20	556	556	1,159	29
30	Repair & Replace Doors & Door Hardware	2013	10,425		20	521	521	1,086	30
31	1650 Sf Roof	2014	6,350		20	635	635	1,217	31
32	2 Sets Of Solid Wood Doors	2014	8,652		20	865	865	1,514	32
33	2 10-Ton Rooftop A/C Units	2014	21,500		20	2,150	2,150	3,763	33
34	TOTAL (lines 1 thru 33)		$ 5,598,498	$ 277,895		$ 215,283	$ (62,612)	$ 1,348,063	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,598,498	$ 277,895		$ 215,283	$ (62,612)	$ 1,348,063	1
2	Sewage & Ground Water Pump System	2014	31,594		20	3,159	3,159	5,002	2
3	1 10-Ton Rooftop Unit	2014	9,975		20	998	998	1,496	3
4	Repair Work On Roof	2014	5,100		20	510	510	723	4
5	8 Panic Bars	2014	6,339		20	634	634	792	5
6	Concrete Walkway	2014	12,300		20	820	820	1,025	6
7	Toilet Exhaust Duct Fire Dampers	2014	80,000		20	8,000	8,000	9,333	7
8	New Circuit Breaker	2014	2,885		20	289	289	313	8
9	1St Floor Resident Room Wallpaper / Painting	2014	61,529		20	6,153	6,153	8,717	9
10	Stairwell Door Replacement	2014	10,350		20	1,035	1,035	1,208	10
11	Drywall 1St & 2Nd Floor And Corridors All Over Facility	2014	42,267		20	2,113	2,113	4,051	11
12	2Nd Floor Handrails & Crashrails	2014	23,900		20	1,195	1,195	2,290	12
13	Gutted & Rebuilt Shower Room - 1St Floor Spa	2014	79,000		20	3,950	3,950	7,571	13
14	Additional Labor For 2Nd Floor Dining Room Floor	2014	8,500		20	425	425	779	14
15	Floor Replacement - 1St Floor	2014	167,000		20	8,350	8,350	12,525	15
16	Repair 12 Doors, Repair Floor In Electrical/Maint Room	2014	4,360		20	218	218	273	16
17	Install Double Swing Gates In Stairwell	2014	4,500		20	225	225	300	17
18	Electric Door Replacement	2015	3,550		20	296	296	296	18
19	1St Floor Resident Rooms-Mold Remediation	2015	48,471		20	4,039	4,039	4,039	19
20	Installation Of The Pit Ladder And Door Restrictor	2015	9,593		20	719	719	719	20
21	Landmark Construction - Swing Gates	2015	4,500		20	338	338	338	21
22	Landmark Construction- Center Flood Plain	2015	4,500		20	338	338	338	22
23	Electrical Work For Generator Installation	2015	130,000		20	9,750	9,750	9,750	23
24	Christy Webber- Landscaping Work	2015	9,000		20	300	300	300	24
25	Mallard Electric- Kohler Generator	2015	56,182		20	2,341	2,341	2,341	25
26	Christy Webber- Landscaping Work	2015	6,000		20	133	133	133	26
27	Seco Redige- Replace Compresor On Walk-In Freezer	2015	5,037		20	126	126	126	27
28	Kone, Inc- 2 Elevators	2015	205,000		20	3,417	3,417	3,417	28
29	Landmark Construction- Wardrobes (Wall Covering, Carpeting, I	2015	57,000		20	1,900	1,900	1,900	29
30	Resident Rooms (100/200 Wing) - Wallcovering, Carpeting, Paint	2015	44,694		20	1,490	1,490	1,490	30
31	16 New Wood Doors	2015	9,506		20	79	79	79	31
32	Insurance Refund	2015	(75,000)		20				32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,666,131	$ 277,895		$ 278,621	$ 726	$ 1,429,725	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,666,131	$ 277,895		$ 278,621	$ 726	$ 1,429,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,666,131	$ 277,895		$ 278,621	$ 726	$ 1,429,725	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,666,131	$ 277,895		$ 278,621	$ 726	$ 1,429,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,666,131	$ 277,895		$ 278,621	$ 726	$ 1,429,725	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 Main/Care Center Building LLC	2002	34,435	883	35	883		11,736	3
4	Allocated from Extended Care Clinical	2002	3,681	94	35	94		1,255	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting	2007	200	10	20	10		90	10
11	Allocated from Extended Care Consulting	2009	120	6	20	6		42	11
12	Allocated from Extended Care Consulting	2010	1,175	59	20	59		352	12
13	Allocated from Extended Care Consulting	2011	423	21	20	21		106	13
14	Allocated from Extended Care Consulting	2012	139	7	20	7		28	14
15	Allocated from Extended Care Consulting	2014	1,931	97	20	97		193	15
16									16
17	Allocated from 2201 Main/Care Center Building LLC	2002	28,446					28,446	17
18	Allocated from 2201 Main/Care Center Building LLC	2003	33,522					33,522	18
19	Allocated from 2201 Main/Care Center Building LLC	2005	1,666	177	20	177		1,663	19
20	Allocated from 2201 Main/Care Center Building LLC	2009	301	15	20	15		105	20
21	Allocated from 2201 Main/Care Center Building LLC	2014	2,795	140	20	140		280	21
22	Allocated from 2201 Main/Care Center Building LLC	2015	474	24	20	24		24	22
23									23
24	Allocated from Extended Care Clinical LLC	2002	3,041		20			3,041	24
25	Allocated from Extended Care Clinical LLC	2003	3,584		20			3,584	25
26	Allocated from Extended Care Clinical LLC	2005	178	19	20	19		178	26
27	Allocated from Extended Care Clinical LLC	2009	32	2	20	2		11	27
28	Allocated from Extended Care Clinical LLC	2014	299	15	20	15		30	28
29	Allocated from Extended Care Clinical LLC	2015	51	3	20	3		3	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 116,493	$ 1,572		$ 1,572	$	$ 84,689	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 116,493	$ 1,572		$ 1,572	$	$ 84,689	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
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16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 116,493	$ 1,572		$ 1,572	$	$ 84,689	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 485,779	$ 858	$ 92,858	$ 92,000	10	$ 173,126	71
72	Current Year Purchases	189,820	134	28,866	28,732	10	38,402	72
73	Fully Depreciated Assets	1,268,819				10	1,268,819	73
74								74
75	TOTALS	$ 1,944,418	$ 992	$ 121,724	$ 120,732		$ 1,480,347	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 Cc	2015	$ 7,858	$ 222	$ 222	$	5	$ 7,192	76
77		Allocated from Extended Care Cl	2012	3,735	747	747		5	2,598	77
78										78
79										79
80	TOTALS			$ 11,593	$ 969	$ 969	$		$ 9,790	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)	$ 8,878,676	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 279,856	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 401,314	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 121,458	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,919,862	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 Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,100 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			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		$		$ 293,425	$		$ 293,425	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				168,144			168,144	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				247,138			247,138	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts					238,647		238,647	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							69,168		69,168	13
14	TOTAL				$		$ 708,707	$ 307,815		$ 1,016,522	14

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

STATE OF ILLINOIS

Facility Name & ID Number South Suburban Rehab Center **#** 0048678 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 91,804	$ 573,805	1
2	Cash-Patient Deposits	8,960	8,960	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,305,284	1,305,284	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	475,584	475,584	6
7	Other Prepaid Expenses	7,404	7,404	7
8	Accounts Receivable (owners or related parties)	195,000	195,000	8
9	Other(specify):	147,111	2,502,505	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,231,147	$ 5,068,542	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		3,342,891	14
15	Leasehold Improvements, at Historical Cost	1,409,667	1,409,667	15
16	Equipment, at Historical Cost	626,639	2,698,639	16
17	Accumulated Depreciation (book methods)	(479,597)	(4,198,286)	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):		200,360	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,556,709	$ 4,053,271	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,787,856	$ 9,121,813	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,985,444	$ 4,985,446	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,516	53,516	28
29	Short-Term Notes Payable	3,321,531	3,321,531	29
30	Accrued Salaries Payable	279,443	279,443	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,331	18,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)	523,947	523,947	32
33	Accrued Interest Payable		34,425	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	543,172	2,308,947	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,725,384	$ 11,525,586	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,413,795	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,413,795	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,725,384	$ 19,939,381	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,937,528)	$ (10,817,568)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,787,856	$ 9,121,813	48

***(See instructions.)**

Facility Name & ID Number South Suburban Rehab Center **#** 0048678 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,053,423)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,053,425)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,884,103)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,884,103)	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)**	$ (5,937,528)	24 *

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,245,002	1
2	Discounts and Allowances for all Levels	(2,761,830)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,483,172	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,519,939	6
7	Oxygen	560	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,520,499	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	247,838	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,475	19
20	Radiology and X-Ray	5,690	20
21	Other Medical Services	130,239	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 396,242	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,156	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,156	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,401,069	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,001,469	31
32	Health Care	4,931,165	32
33	General Administration	3,313,328	33
	B. Capital Expense		
34	Ownership	1,558,597	34
	C. Ancillary Expense		
35	Special Cost Centers	1,016,522	35
36	Provider Participation Fee	464,091	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,285,172	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,884,103)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,884,103)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,756,084	44
45	Private Pay - Net Inpatient Revenue	537,064	45
46	Medicare - Net Inpatient Revenue	153,848	46
47	Other-(specify) Hospice	1,039,791	47
48	Other-(specify) Insurance	(3,615)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,483,172	49

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,857	1,943	$ 90,578	$ 46.62	1
2	Assistant Director of Nursing	1,640	1,739	69,275	39.84	2
3	Registered Nurses	18,727	20,282	693,476	34.19	3
4	Licensed Practical Nurses	51,191	54,939	1,577,553	28.71	4
5	CNAs & Orderlies	104,269	115,462	1,180,345	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,515	16,443	275,392	16.75	8
9	Activity Director	2,113	2,342	42,390	18.10	9
10	Activity Assistants	16,846	18,171	207,152	11.40	10
11	Social Service Workers	9,030	9,617	244,289	25.40	11
12	Dietician	1,135	1,259	27,626	21.94	12
13	Food Service Supervisor	598	633	11,388	17.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,363	9,665	112,678	11.66	15
16	Dishwashers	14,609	16,268	162,047	9.96	16
17	Maintenance Workers	7,816	8,344	139,435	16.71	17
18	Housekeepers	28,580	31,116	320,885	10.31	18
19	Laundry	5,109	5,793	68,047	11.75	19
20	Administrator	2,086	2,195	118,110	53.81	20
21	Assistant Administrator	1,973	2,162	55,758	25.79	21
22	Other Administrative	893	981	24,483	24.96	22
23	Office Manager					23
24	Clerical	6,179	6,581	111,281	16.91	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	3,072	3,423	46,902	13.70	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,736	2,933	42,829	14.60	33
34	TOTAL (lines 1 - 33)	303,337	332,291	$ 5,621,919 *	$ 16.92	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	772	$ 37,629	01-03	35
36	Medical Director	Monthly	57,050	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,840	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	16,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	772	$ 122,519		49

C. CONTRACT NURSES

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nikki Dinsmore	Administrator	0	$ 118,110
Nichole Green	Assist. Admin	0	55,758
Elimelech Mayer	Assist. Admin	0	24,483
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 198,351

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
Ext. Care Consulting	Home Office Expense	$ 363,774
Ext. Care Clinical	Home Office Expense	121,248
FR&R / Marcum LLP	Accounting	25,949
Personnel Planners	Unemployment Tax Cons.	4,899
See Attached	Legal	139,021
e-Health Data Solutions	MDS Software	3,180
AIS Assessment & Intelligence	MDS Training	1,319
Ability Network	Medicare Billing	2,145
National Datacare Corporation	Resident Fund Processing	2,327
Pro Payroll Solutions	Payroll Processing	31,695
Plante & Moran	Accounting	1,000
See Supplemental Schedule		11,335
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 707,892

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 257,006
Unemployment Compensation Insurance	196,004
FICA Taxes	427,148
Employee Health Insurance	238,494
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,485
Pension Expense	13,806
Other Employee Welfare	6,643
Holiday Expense	1,785
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,142,372

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	8,153
Health Care Worker Background Check	7,960
(Indicate # of checks performed 604)	
Patient Background Checks	
Dues and Subscriptions	26,183
Licenses and Permits	2,007
Alloc. Ext. Care Clinical	215
Alloc. Ext. Care Consulting	1,199
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,707

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,322
Alloc. Ext. Care Clinical	1,353
Alloc. Ext. Care Consulting	412
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,087

**See instructions.

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. **ICLTC $22,222**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **66,504** 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 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. $ **464,091**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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