FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,794	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,794	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	48,176	2,523	9,790	60,489	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,176	2,523	9,790	60,489	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.81%

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 4,716

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	349,356	101,724	45,054	496,134		496,134	12,132	508,266			1
2	Food Purchase		363,246		363,246		363,246	341	363,587			2
3	Housekeeping	325,128	51,913		377,041		377,041	1,398	378,439			3
4	Laundry	55,734	28,592		84,326		84,326		84,326			4
5	Heat and Other Utilities			241,293	241,293		241,293	1,934	243,227			5
6	Maintenance	142,066		291,382	433,448		433,448	(307)	433,141			6
7	Other (specify):*							8,641	8,641			7
8	TOTAL General Services	872,284	545,475	577,729	1,995,488		1,995,488	24,139	2,019,627			8
	B. Health Care and Programs											
9	Medical Director			60,000	60,000		60,000		60,000			9
10	Nursing and Medical Records	3,668,800	360,599	31,054	4,060,453		4,060,453	44,684	4,105,137			10
10a	Therapy	339,874			339,874		339,874		339,874			10a
11	Activities	272,345	21,586		293,931		293,931		293,931			11
12	Social Services	257,033	10,533		267,566		267,566	28,825	296,391			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	43,179			43,179		43,179	10,824	54,003			15
16	TOTAL Health Care and Programs	4,581,231	392,718	91,054	5,065,003		5,065,003	84,333	5,149,336			16
	C. General Administration											
17	Administrative	181,182			181,182		181,182	121,074	302,256			17
18	Directors Fees											18
19	Professional Services			687,248	687,248	(22,830)	664,418	(530,961)	133,457			19
20	Dues, Fees, Subscriptions & Promotions			102,250	102,250		102,250	(33,364)	68,886			20
21	Clerical & General Office Expenses	120,546	44,630	892,930	1,058,106		1,058,106	(605,771)	452,335			21
22	Employee Benefits & Payroll Taxes			1,162,331	1,162,331		1,162,331	(25,151)	1,137,180			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,340	4,340		4,340	1,092	5,432			24
25	Other Admin. Staff Transportation			8,356	8,356		8,356	1,273	9,629			25
26	Insurance-Prop.Liab.Malpractice			569,099	569,099		569,099	2,957	572,056			26
27	Other (specify):*							49,460	49,460			27
28	TOTAL General Administration	301,728	44,630	3,426,554	3,772,912	(22,830)	3,750,082	(1,019,391)	2,730,691			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,755,243	982,823	4,095,337	10,833,403	(22,830)	10,810,573	(910,919)	9,899,654			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: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			298,244	298,244		298,244	92,684	390,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,531	98,531		98,531	375,537	474,068			32
33	Real Estate Taxes			518,606	518,606	22,830	541,436	5,691	547,127			33
34	Rent-Facility & Grounds			780,000	780,000		780,000	(780,000)				34
35	Rent-Equipment & Vehicles			4,281	4,281		4,281	1,203	5,484			35
36	Other (specify):*			878	878		878	(878)				36
37	**TOTAL Ownership**			1,700,540	1,700,540	22,830	1,723,370	(305,763)	1,417,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		162,185	978,675	1,140,860		1,140,860	(7,319)	1,133,541			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			470,973	470,973		470,973		470,973			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		162,185	1,449,648	1,611,833		1,611,833	(7,319)	1,604,514			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,755,243	1,145,008	7,245,525	14,145,776		14,145,776	(1,224,001)	12,921,775			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: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(37,150)	30		9
10	Interest and Other Investment Income	(805)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(150)	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	(803)	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	(746,450)	21		24
25	Fund Raising, Advertising and Promotional	(26,324)	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	(276,678)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,088,360)		$	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)	(135,641)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (135,641)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,224,001)		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: 01/01/16
Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (1,229)	10	1
2	Collection Expense	(12,258)	21	2
3	Amortization	(878)	36	3
4	Annual Report	(250)	20	4
5	Chambers of Commerce Dues	(370)	20	5
6	PAC Dues	(8,983)	20	6
7	Lobbying	(3,833)	21	7
8	Non - Allowable Legal	(54,212)	19	8
9	Building Co - State Income tax	(886)	21	9
10	Building Co - Management Fee	(2,625)	17	10
11	Building Co - Filing Fee	(250)	20	11
12	Building Co - Bank Charge	(20)	21	12
13	Building Co - Amortization	(175,564)	31	13
14	Capitalized R&M	(15,320)	06	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**	(276,678)		49

South Suburban Rehab Center

ID# 0048678

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES 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			228		11,904							12,132	1
2	Food Purchase	(150)		491									341	2
3	Housekeeping			1,262		136							1,398	3
4	Laundry													4
5	Heat and Other Utilities			1,760		174							1,934	5
6	Maintenance	(15,320)		3,676	11,015	322							(307)	6
7	Other (specify):*				6,997	1,644							8,641	7
8	**TOTAL General Services**	(15,470)		7,417	18,012	14,180							24,139	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,229)				49,525	(3,612)						44,684	10
10a	Therapy													10a
11	Activities													11
12	Social Services					28,825							28,825	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,824							10,824	15
16	**TOTAL Health Care and Programs**	(1,229)				89,174	(3,612)						84,333	16
	C. General Administration													
17	Administrative	(2,625)	2,625	3,680	20,948	96,446							121,074	17
18	Directors Fees													18
19	Professional Services	(54,212)		(356,397)		(120,352)							(530,961)	19
20	Fees, Subscriptions & Promotions	(36,177)	250	1,194		1,369							(33,364)	20
21	Clerical & General Office Expenses	(764,250)	341	7,414	126,942	23,782							(605,771)	21
22	Employee Benefits & Payroll Taxes				(25,151)								(25,151)	22
23	Inservice Training & Education													23
24	Travel and Seminar			187		905							1,092	24
25	Other Admin. Staff Transportation			1,273									1,273	25
26	Insurance-Prop.Liab.Malpractice			2,203		754							2,957	26
27	Other (specify):*				33,342	16,118							49,460	27
28	**TOTAL General Administration**	(857,264)	3,216	(340,446)	156,081	19,022							(1,019,391)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(873,963)	3,216	(333,029)	174,093	122,376	(3,612)						(910,919)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Suburban Rehab Center # 0048678 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(37,150)	126,011	2,937		886							92,684	30
31	Amortization of Pre-Op. & Org.	(175,564)	175,564											31
32	Interest	(805)	365,425	10,662		255							375,537	32
33	Real Estate Taxes			5,136		555							5,691	33
34	Rent-Facility & Grounds		(780,000)										(780,000)	34
35	Rent-Equipment & Vehicles			1,203									1,203	35
36	Other (specify):*	(878)											(878)	36
37	**TOTAL Ownership**	(214,397)	(113,000)	19,938		1,696							(305,763)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(7,319)						(7,319)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(7,319)						(7,319)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,088,360)	(109,784)	(313,091)	174,093	124,072	(10,931)						(1,224,001)	45

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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	21	State Income Tax		Homewood Mercy Property, LLC	100.00%	886	886	2
3	V	17	Management Fee		Homewood Mercy Property, LLC	100.00%	2,625	2,625	3
4	V	20	Filing Fee		Homewood Mercy Property, LLC	100.00%	250	250	4
5	V	21	Bank Charge		Homewood Mercy Property, LLC	100.00%	20	20	5
6	V	30	Depreciation		Homewood Mercy Property, LLC	100.00%	126,011	126,011	6
7	V	31	Amortization		Homewood Mercy Property, LLC	100.00%	175,564	175,564	7
8	V	32	Interest Expense		Homewood Mercy Property, LLC	100.00%	365,425	365,425	8
9	V	21	Misc Income	565	Homewood Mercy Property, LLC	100.00%		(565)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 780,565			$ 670,781	$ * (109,784)	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 228	$ 228	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	491	491	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,262	1,262	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,760	1,760	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,676	3,676	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,680	3,680	20
21	V	19	Professional Fees	363,744	Extended Care Consulting, LLC	100.00%	7,347	(356,397)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,194	1,194	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	7,414	7,414	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	187	187	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,273	1,273	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,203	2,203	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,937	2,937	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	10,662	10,662	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,136	5,136	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,203	1,203	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			$ 50,653	$ * (313,091)	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	11,015	$ 11,015	15
16	V	06	Maintenance (Direct)	52,624	Extended Care Consulting, LLC	100.00%	52,624		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,032	1,032	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	5,965	5,965	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	20,948	20,948	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	126,942	126,942	22
23	V	21	Office and Clerical (Direct)	31,213	Extended Care Consulting, LLC	100.00%	31,213		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	27,049	27,049	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	6,293	6,293	25
26	V	22	Employee Benefits	25,151	Extended Care Consulting, LLC	100.00%		(25,151)	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			$ 108,988			$ 283,081	$ * 174,093	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 136	$ 136	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	174	174	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	322	322	17
18	V	19	Professional Fees	121,248	Extended Care Clinical, LLC	100.00%	896	(120,352)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,369	1,369	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	3,558	3,558	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	905	905	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	754	754	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	886	886	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	255	255	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	555	555	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	11,904	11,904	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,644	1,644	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	49,525	49,525	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	28,825	28,825	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	10,824	10,824	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	96,446	96,446	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	20,224	20,224	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	16,118	16,118	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,248			$ 245,320	$ * 124,072	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 50,145	MAC Rx, LLC	100.00%	$ 46,534	$ (3,612)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	101,625	MAC Rx, LLC	100.00%	94,306	(7,319)	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			$ 151,770			$ 140,840	$ * (10,931)	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 289,691	$ 289,691	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	289,691	CCS Employee Benefits Group	100.00%		(289,691)	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			$ 289,691			$ 289,691	$ *	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	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	C.C.S. Veba	Evanston	Health Insurance	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	Des Plaines	Pharmacy	7
8			MAJOR HOSPITAL DYER	DYER, IN	Reliable Medical Supply	Des Plaines	Medical Supplies	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	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	1.47	3.68%	Alloc. Salary	$ 2,699	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.49	6.35%	Alloc Sal/Mgmt	12,648	17-7	2
3	Kimberly Rudolph	Relative	Clerical	N/A	See Attached	0.33	4.38%	Alloc. Salary	102	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 15,449		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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,380,761	34	$ 5,206	$	60,489	$ 228	1
2	02	Food	Patient Days	1,380,761	34	11,203		60,489	491	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		60,489	1,262	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		60,489	1,760	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		60,489	3,676	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		60,489	3,680	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		60,489	7,347	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		60,489	1,194	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		60,489	7,414	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		60,489	187	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		60,489	1,273	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		60,489	2,203	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		60,489	2,937	13
14	32	Interest	Patient Days	1,380,761	34	243,379		60,489	10,662	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		60,489	5,136	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		60,489	1,203	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 50,653	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	60,489	11,015	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		52,624	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		60,489	1,032	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			5,965	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	60,489	20,948	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	60,489	126,942	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		31,213	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		60,489	27,049	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			6,293	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,222,483	$ 4,461,323		$ 283,081	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	818,091	19	$ 1,844	$	60,489	$ 136	1
2	05	Utilities	Patient Days	818,091	19	2,355		60,489	174	2
3	06	Maintenance	Patient Days	818,091	19	4,352		60,489	322	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		60,489	896	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		60,489	1,369	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		60,489	3,558	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		60,489	905	7
8	26	Insurance	Patient Days	818,091	19	10,196		60,489	754	8
9	30	Depreciation	Patient Days	818,091	19	11,978		60,489	886	9
10	32	Interest	Patient Days	818,091	19	3,446		60,489	255	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		60,489	555	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	60,489	11,904	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		60,489	1,644	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	60,489	49,525	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	60,489	28,825	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		60,489	10,824	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	60,489	96,446	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	60,489	20,224	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		60,489	16,118	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,317,844	$ 2,798,561		$ 245,320	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 46,534	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						94,306	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					$	$		$ 140,840	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 289,691	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					$	$		$ 289,691	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Chemical Bank		X	Mortgage			$	$ 8,111,656			$ 365,425	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	DAIWA		X	Line of Credit				5,113,711			98,531	6
7	Allocated from EC Consulting	X									10,662	7
8	Allocated from EC Clinical	X			-						255	8
9	TOTAL Facility Related						$	$ 13,225,367			$ 474,873	9
	B. Non-Facility Related*											
10	Interest Income		X								(805)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (805)	14
15	TOTALS (line 9+line14)						$	$ 13,225,367			$ 474,068	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: 01/01/16 Ending: 12/31/16

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehab Center **#** 0048678 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	523,934	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.)	$	514,247	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,687)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	533,984	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.)**	$	22,830	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** $ 62,543 **For** 2013 **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.	$	547,127	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	409,816	8
	2012	438,945	9
	2013	447,829	10
	2014	498,997	11
	2015	508,556	12

2016 Accrual = $508,556 x 1.05 = $533,984
Allocated from EC Consulting - $5,136
Allocated from EC Clinical - $555

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-05-400-011-0000	Long Term Property Care	$ 508,556.29	$ 508,556.29
2.	See Attached	Allocated from EC Consulting	$ 167,518.13	$ 5,135.82
3.	See Attached	Allocated from EC Clinical	$ 7,506.21	$ 555.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 683,580.63	$ 514,247.11

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Allocated from EC Clinical/Consulting			27,857	2
3	TOTALS			$ 256,732	3

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	259		2007	1976	$ 4,495,349	$ 126,011	35	$ 128,439	$ 2,428	$ 1,098,765	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	32,656		20	911	911	22,903	9
10	Various			2008	35,282		20	2,042	2,042	18,075	10
11	Various			2009	29,244		20	1,330	1,330	13,173	11
12	Various			2010	36,366		20	1,460	1,460	17,517	12
13	Various			2011	151,861		20	9,495	9,495	64,744	13
14	Various			2012	138,638		20	8,564	8,564	40,933	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		132,251	1,840		1,840		89,112	68
69	Financial Statement Depreciation			298,244			(298,244)		69
70	TOTAL (lines 4 thru 69)		$ 5,051,647	$ 426,095		$ 154,081	$ (272,014)	$ 1,365,222	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,051,647	$ 426,095		$ 154,081	$ (272,014)	$ 1,365,222	1
2	Sprinkler Heads - Installed Mac Tee To 4X2	2013	9,780		20	489	489	1,956	2
3	Wires From 120V Ac Output To Each Door	2013	9,000		20	450	450	1,800	3
4	Furn/Inst 2 Door Restrictors,Fire Key Boxes-Elevator,Pit Stop Sw	2013	5,589		20	279	279	1,118	4
5	Installed Sprinkler In Elevator Pits- 4 " Mac Tee Cut Pipe, 1"Wat	2013	3,390		20	170	170	678	5
6	Installed Bearing With Pump Seal, Coupler, And Body Gasket In	2013	4,177		20	835	835	3,202	6
7	Ceiling Panels	2013	5,508		20	275	275	1,010	7
8	Installed One Three Pole 70 Ampere Circuit Breaker On First Flo	2013	4,500		20	225	225	825	8
9	Spray Fireproofing	2013	10,690		20	535	535	1,960	9
10	Installed A Ejector Pump In Basement	2013	3,375		20	169	169	577	10
11	Replaced Entire Walkway Concrete On Loading Dock, Repaired E	2013	14,800		20	740	740	2,467	11
12	Replacement Of Fire Alarm System & Devices	2013	11,320		20	2,264	2,264	7,547	12
13	Replaced Smoke Detectors And Duct Detectors On 2Nd Floor	2013	6,430		20	1,286	1,286	4,287	13
14	Installed Flooring On 1St Floor Cooridors, Lounges, Living & Din	2013	118,000		20	23,600	23,600	72,767	14
15	East Side Of Lobby/Basement - Installed Dry System, Piping, Spri	2013	28,000		20	718	718	2,842	15
16	Elevator Machine Room Sprinkler - Smoke/Heat Detectors, Sprinl	2013	7,995		20	205	205	811	16
17	Installed 70 Sprinkler Heads On The 2Nd Floor	2013	4,536		20	116	116	354	17
18	Installed Exit Signs In Pt Room, 410 Hall Exit, Hallways In Basem	2013	3,500		20	90	90	273	18
19	Roof Over 800/500/Middle Flat Roof; Installed 15Yr White Pvs Re	2013	162,164		20	16,216	16,216	63,514	19
20	Installed 6 Drains, 6 Pitch Pans, Flashers, And Flashing Rails On I	2013	66,800		20	3,340	3,340	11,690	20
21	Replaced Broken Gas Line And Installed New Pipe And Fittings	2013	8,175		20	409	409	1,397	21
22	Ceiling Grid-2Nd Fl/Ceiling Panels/Fire Sprinkler/Sink Base Cabi	2013	16,830		20	842	842	2,945	22
23	Patching & Fire Caulking In Various Locations	2013	11,123		20	556	556	1,715	23
24	Repair & Replace Doors & Door Hardware	2013	10,425		20	521	521	1,607	24
25	1650 Sf Roof	2014	6,350		20	635	635	1,852	25
26	2 Sets Of Solid Wood Doors	2014	8,652		20	865	865	2,379	26
27	2 10-Ton Rooftop A/C Units	2014	21,500		20	2,150	2,150	5,913	27
28	Sewage & Ground Water Pump System	2014	31,594		20	3,159	3,159	8,162	28
29	1 10-Ton Rooftop Unit	2014	9,975		20	998	998	2,494	29
30	Repair Work On Roof	2014	5,100		20	510	510	1,233	30
31	8 Panic Bars	2014	6,339		20	634	634	1,426	31
32	Concrete Walkway	2014	12,300		20	820	820	1,845	32
33	Toilet Exhaust Duct Fire Dampers	2014	80,000		20	8,000	8,000	17,333	33
34	TOTAL (lines 1 thru 33)		$ 5,759,564	$ 426,095		$ 226,182	$ (199,913)	$ 1,595,199	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,759,564	$ 426,095		$ 226,182	$ (199,913)	$ 1,595,199	1
2	New Circuit Breaker	2014	2,885		20	289	289	601	2
3	1St Floor Resident Room Wallpaper / Painting	2014	61,529		20	6,153	6,153	14,870	3
4	Stairwell Door Replacement	2014	10,350		20	1,035	1,035	2,243	4
5	Drywall 1St & 2Nd Floor And Corridors All Over Facility	2014	42,267		20	2,113	2,113	6,164	5
6	2Nd Floor Handrails & Crashrails	2014	23,900		20	1,195	1,195	3,485	6
7	Gutted & Rebuilt Shower Room - 1St Floor Spa	2014	79,000		20	3,950	3,950	11,521	7
8	Additional Labor For 2Nd Floor Dining Room Floor	2014	8,500		20	425	425	1,204	8
9	Floor Replacement - 1St Floor	2014	167,000		20	8,350	8,350	20,875	9
10	Repair 12 Doors, Repair Floor In Electrical/Maint Room	2014	4,360		20	218	218	491	10
11	Install Double Swing Gates In Stairwell	2014	4,500		20	225	225	525	11
12	Electric Door Replacement	2015	3,550		20	178	178	325	12
13	Landmark Construction Performed 1St Floor Resident Rooms	2015	48,471		20	2,424	2,424	4,443	13
14	Installation Of The Pit Ladder And Door Restrictor	2015	9,593		20	480	480	839	14
15	Landmark Construction - Swing Gates	2015	4,500		20	225	225	394	15
16	Landmark Construction- Center Flood Plain	2015	4,500		20	225	225	394	16
17	Electrical Work For Generator Installation	2015	130,000		20	6,500	6,500	11,375	17
18	Christy Webber- Landscaping Work	2015	9,000		20	450	450	675	18
19	Mallard Electric- Kohler Generator	2015	56,182		20	2,809	2,809	3,980	19
20	Christy Webber- Landscaping Work	2015	6,000		20	300	300	400	20
21	Seco Redige- Replace Compresor On Walk-In Freezer	2015	5,037		20	252	252	315	21
22	Kone, Inc- 2 Elevators	2015	205,000		20	10,250	10,250	11,958	22
23	Landmark Construction- Wardrobes (Wall Covering, Carpeting, I	2015	57,000		20	2,850	2,850	3,325	23
24	Resident Rooms (100/200 Wing) - Wallcovering, Carpeting, Paint	2015	44,694		20	2,235	2,235	2,607	24
25	16 New Wood Doors	2015	9,506		20	475	475	515	25
26	Insurance Refund	2015	(75,000)		20	(3,750)	(3,750)	(5,938)	26
27	Relocate Em Circuits	2015	2,741		20	137	137	137	27
28	New Generator Panel & Relocate Em Circuits	2015	9,980		20	499	499	499	28
29	Repair Head Wall In 12 Rooms	2015	7,918		20	396	396	396	29
30	Wander Guard On 2 Doors	2016	5,004		20	250	250	250	30
31	Additional Work For Generator	2016	25,500		20	1,169	1,169	1,169	31
32	1 10-Ton Rooftop Unit (Out Of 12)	2016	10,250		20	427	427	427	32
33	Kitchen Exhaust Fan	2016	6,850		20	257	257	257	33
34	TOTAL (lines 1 thru 33)		$ 6,750,132	$ 426,095		$ 279,171	$ (146,924)	$ 1,695,920	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,750,132	$ 426,095		$ 279,171	$ (146,924)	$ 1,695,920	1
2	Elevator Work	2016	13,280		20	498	498	498	2
3	Asbestos Removal In Elevator	2016	4,000		20	117	117	117	3
4	Electrical Work For Elevator Rebuild	2016	16,340		20	272	272	272	4
5	Pump Out 2 Catch Basins, New 100 Gallon Grease Trap	2016	10,000		20	42	42	42	5
6	Walk-In Cooler Floor	2016	2,718		20	23	23	23	6
7	Fan Curtain	2016	8,578		20	36	36	36	7
8	Elevator Work	2016	10,860		20	362	362	362	8
9	Replaced Sensors & Bottom Rollers On Automatic Door	2016	2,508		20	125	125	125	9
10	Sewage And Plumbing, Removed & Replaced Bad Pipes	2016	9,500		20	475	475	475	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)		$ 6,827,915	$ 426,095		$ 281,120	$ (144,975)	$ 1,697,869	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,827,915	$ 426,095		$ 281,120	$ (144,975)	$ 1,697,869	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)		$ 6,827,915	$ 426,095		$ 281,120	$ (144,975)	$ 1,697,869	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated EC Consulting	2002	34,644	888	35	888		12,695	3
4	Allocated EC Clinical	2002	3,744	96	35	96		1,372	4
5	Allocated EC Consulting - Dyer Building	2007	10,514	233	35	233		2,212	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from EC Clinical	2002	3,093		20			3,093	9
10	Allocated from EC Clinical	2003	3,645		20			3,645	10
11	Allocated from EC Clinical	2005	181		20			181	11
12	Allocated from EC Clinical	2009	33	2	20	2		13	12
13	Allocated from EC Clinical	2014	304	15	20	15		46	13
14	Allocated from EC Clinical	2015	52	3	20	3		5	14
15	Allocated from EC Clinical	2016	204	10	20	10		10	15
16									16
17	Allocated from EC Consulting	2002	28,619		20			28,619	17
18	Allocated from EC Consulting	2003	33,726		20			33,726	18
19	Allocated from EC Consulting	2005	1,676	3	20	3		1,676	19
20	Allocated from EC Consulting	2007	202	10	20	10		101	20
21	Allocated from EC Consulting	2009	302	15	20	15		121	21
22	Allocated from EC Consulting	2009	120	6	20	6		48	22
23	Allocated from EC Consulting	2010	1,182	59	20	59		414	23
24	Allocated from EC Consulting	2011	425	21	20	21		128	24
25	Allocated from EC Consulting	2012	140	7	20	7		35	25
26	Allocated from EC Consulting	2014	1,943	97	20	97		292	26
27	Allocated from EC Consulting	2014	2,812	141	20	141		422	27
28	Allocated from EC Consulting	2015	477	24	20	24		48	28
29	Allocated from EC Consulting	2016	1,883	94	20	94		94	29
30	Allocated from EC Consulting	2016	2,330	116	20	116		116	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 132,251	$ 1,840		$ 1,840	$	$ 89,112	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 132,251	$ 1,840		$ 1,840	$	$ 89,112	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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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)		$ 132,251	$ 1,840		$ 1,840	$	$ 89,112	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 636,319	$ 999	$ 108,492	$ 107,493	10	$ 270,221	71
72	Current Year Purchases	3,312		331	331	10	331	72
73	Fully Depreciated Assets	1,298,977				10	1,298,977	73
74								74
75	TOTALS	$ 1,938,608	$ 999	$ 108,823	$ 107,824		$ 1,569,529	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 EC Consulting	2016	$ 7,906	$ 223	$ 223	$	5	$ 7,459	76
77		Allocated from EC Clinical	2016	3,799	760	760		5	3,402	77
78										78
79										79
80	TOTALS			$ 11,705	$ 983	$ 983	$		$ 10,861	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)	$ 9,034,961	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 428,077	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 390,927	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,150)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,278,258	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: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,484 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: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	$		$ 380,706	$		$ 380,706	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			181,148			181,148	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			416,821			416,821	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				101,625		101,625	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						60,560		60,560	13
14	TOTAL			$		$ 978,675	$ 162,185		$ 1,140,860	14

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

Facility Name & ID Number South Suburban Rehab Center **#** 0048678 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,377	$ 709,780	1
2	Cash-Patient Deposits	46,885	46,885	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,736,537	1,736,537	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	569,460	569,460	6
7	Other Prepaid Expenses	8,237	8,237	7
8	Accounts Receivable (owners or related parties)	195,000	1,516,907	8
9	Other(specify): See Attached Schedule	80,696	508,405	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,646,192	$ 5,096,211	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	1,885,575	1,885,575	15
16	Equipment, at Historical Cost	439,028	2,511,028	16
17	Accumulated Depreciation (book methods)	(860,107)	(4,704,807)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	3,637	32,983	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,468,133	$ 3,667,670	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,114,325	$ 8,763,881	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,919,210	$ 4,639,211	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,347	47,347	28
29	Short-Term Notes Payable	5,113,711	5,113,711	29
30	Accrued Salaries Payable	315,721	315,721	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,487	20,487	31
32	Accrued Real Estate Taxes(Sch.IX-B)	533,984	533,984	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	461,743	2,045,348	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 11,412,203	$ 12,715,809	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,111,656	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)**	$	$ 8,111,656	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,412,203	$ 20,827,465	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,297,878)	$ (12,063,584)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,114,325	$ 8,763,881	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,937,528)	1
2	Restatements (describe):		2
3	**Depreciation**	(82,266)	3
4	**Other Income - Insurance Proceeds**	164,286	4
5	**Rounding**	2	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,855,506)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,442,372)	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)**	$ (1,442,372)	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)**	$ (7,297,878)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,266,616	1
2	Discounts and Allowances for all Levels	(2,972,655)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,293,961	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,171,026	6
7	Oxygen	60	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,171,086	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	134,560	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,074	19
20	Radiology and X-Ray	5,630	20
21	Other Medical Services	10,745	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 175,009	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	805	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 805	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	62,543	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 62,543	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,703,404	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,995,488	31
32	Health Care	5,065,003	32
33	General Administration	3,772,912	33
	B. Capital Expense		
34	Ownership	1,700,540	34
	C. Ancillary Expense		
35	Special Cost Centers	1,140,860	35
36	Provider Participation Fee	470,973	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,145,776	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,442,372)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,442,372)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,755,267	44
45	Private Pay - Net Inpatient Revenue	523,753	45
46	Medicare - Net Inpatient Revenue	352,558	46
47	Other-(specify) Hospice	671,909	47
48	Other-(specify) Insurance	(9,526)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,293,961	49

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,075	2,208	$ 104,466	$ 47.31	1
2	Assistant Director of Nursing	2,089	2,287	85,953	37.58	2
3	Registered Nurses	17,007	17,660	622,026	35.22	3
4	Licensed Practical Nurses	51,920	55,291	1,609,570	29.11	4
5	CNAs & Orderlies	96,266	104,792	1,123,618	10.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	20,029	21,729	339,874	15.64	8
9	Activity Director	1,944	2,170	39,298	18.11	9
10	Activity Assistants	18,948	20,376	233,047	11.44	10
11	Social Service Workers	10,568	11,199	257,033	22.95	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,220	40,349	18.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,858	7,207	86,266	11.97	15
16	Dishwashers	20,049	21,911	222,741	10.17	16
17	Maintenance Workers	8,785	9,290	142,066	15.29	17
18	Housekeepers	28,678	31,693	325,128	10.26	18
19	Laundry	4,301	4,695	55,734	11.87	19
20	Administrator	2,091	2,196	120,203	54.74	20
21	Assistant Administrator	2,033	2,191	56,663	25.86	21
22	Other Administrative	171	179	4,316	24.11	22
23	Office Manager					23
24	Clerical	6,621	7,209	120,546	16.72	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	3,522	3,915	53,608	13.69	31
32	Other Health Care(specify)					32
33	Other(specify)	8,448	9,216	112,738	12.23	33
34	TOTAL (lines 1 - 33)	314,443	339,634	$ 5,755,243 *	$ 16.95	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	867	$ 45,054	01-03	35
36	Medical Director	Monthly	60,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,054	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	18,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	867	$ 136,108		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nikki Dinsmore	Administrator	0	$ 120,203
Nichole Cole	Asst. Admin	0	56,663
Shicole Ashfod	Asst. Admin	0	4,316
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 181,182

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
Marcum LLP	Accounting	$ 24,350
ECC Clinical	Home Office Expense	121,248
ECC Consulting	Home Office Expense	363,744
Personnel Planners	Unemployment Tax Cons.	2,886
Paycor	Payroll Services	36,736
eHealth Data Solutions	MDS Software	1,590
Ability Network	Medicare Billing	231
National Datacare Corporation	Resident Fund Processing	2,150
See Attached	Legal Fees	99,147
Blymas	Tax Credit Service	5,145
Advanced Discovery Inc	Data Management	164
See Supplemental Schedule		29,857
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 687,248

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 266,667
Unemployment Compensation Insurance	209,916
FICA Taxes	414,896
Employee Health Insurance	225,972
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	55
Pension Expense	9,584
Other Employee Welfare	7,581
Holiday Expense	2,509
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,137,180

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	14,809
Health Care Worker Background Check	10,228
(Indicate # of checks performed 785)	
Patient Background Checks	
Dues & Subscriptions	33,623
Licenses & Fees	5,673
Allocated from EC Consulting	1,194
Allocated from EC Clinical	1,369
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 68,886

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,340
Allocated from EC Consulting	187
Allocated from EC Clinical	905
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,432

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $27,222**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,783** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **470,973**
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