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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0048678

Facility Name: South Suburban Rehabilitation Center, Llc

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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 01/01/17 to 12/31/17 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, 9 Parkway North, Suite 200 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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	53,118	2,844	4,727	60,689	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,118	2,844	4,727	60,689	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.20%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 3,718

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	344,906	92,117	42,470	479,493		479,493	12,412	491,905			1
2	Food Purchase		352,625		352,625		352,625	500	353,125			2
3	Housekeeping	355,425	42,321		397,746		397,746	1,547	399,293			3
4	Laundry	58,620	33,567		92,187		92,187		92,187			4
5	Heat and Other Utilities			205,483	205,483		205,483	1,896	207,379			5
6	Maintenance	108,447		327,227	435,674		435,674	2,901	438,575			6
7	Other (specify):*							9,354	9,354			7
8	TOTAL General Services	867,398	520,630	575,180	1,963,208		1,963,208	28,610	1,991,818			8
	B. Health Care and Programs											
9	Medical Director			60,000	60,000		60,000		60,000			9
10	Nursing and Medical Records	3,487,903	306,443	863,538	4,657,884		4,657,884	49,001	4,706,885			10
10a	Therapy	245,176			245,176		245,176		245,176			10a
11	Activities	234,165	29,470		263,635		263,635		263,635			11
12	Social Services	271,898	4,453		276,351		276,351	43,870	320,221			12
13	CNA Training											13
14	Program Transportation			660	660		660		660			14
15	Other (specify):*	64,098			64,098		64,098	13,839	77,937			15
16	TOTAL Health Care and Programs	4,303,240	340,366	924,198	5,567,804		5,567,804	106,710	5,674,514			16
	C. General Administration											
17	Administrative	121,027			121,027		121,027	131,294	252,321			17
18	Directors Fees											18
19	Professional Services			631,159	631,159	(18,251)	612,908	(497,036)	115,872			19
20	Dues, Fees, Subscriptions & Promotions			109,626	109,626		109,626	(34,248)	75,378			20
21	Clerical & General Office Expenses	121,167	32,175	790,734	944,076		944,076	(563,404)	380,672			21
22	Employee Benefits & Payroll Taxes			1,136,946	1,136,946		1,136,946	(26,357)	1,110,589			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,460	6,460		6,460	1,628	8,088			24
25	Other Admin. Staff Transportation			4,352	4,352		4,352	1,138	5,490			25
26	Insurance-Prop.Liab.Malpractice			494,743	494,743		494,743	2,866	497,609			26
27	Other (specify):*							50,017	50,017			27
28	TOTAL General Administration	242,194	32,175	3,174,020	3,448,389	(18,251)	3,430,138	(934,102)	2,496,036			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,412,832	893,171	4,673,398	10,979,401	(18,251)	10,961,150	(798,782)	10,162,368			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 Rehabilitation Center, Llc #0048678 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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			298,933	298,933		298,933	91,350	390,283			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			254,076	254,076		254,076	429,292	683,368			32
33	Real Estate Taxes			516,186	516,186	18,251	534,437	5,769	540,206			33
34	Rent-Facility & Grounds			780,000	780,000		780,000	(780,000)				34
35	Rent-Equipment & Vehicles			4,572	4,572		4,572	1,257	5,829			35
36	Other (specify):*			1,505	1,505		1,505	(1,505)	(0)			36
37	**TOTAL Ownership**			1,855,272	1,855,272	18,251	1,873,523	(253,837)	1,619,686			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,758	971,636	1,031,394		1,031,394	(9,087)	1,022,307			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			491,356	491,356		491,356		491,356			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		59,758	1,462,992	1,522,750		1,522,750	(9,087)	1,513,663			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,412,832	952,929	7,991,662	14,357,423		14,357,423	(1,061,706)	13,295,717			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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(38,156)	30		9
10	Interest and Other Investment Income	(5,038)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(164)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(708,764)	21		24
25	Fund Raising, Advertising and Promotional	(22,953)	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	(1,308,548)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,083,623)		$	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)	1,021,916		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,021,916		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,061,707)		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

STATE OF ILLINOIS

South Suburban Rehabilitation Center, Llc

ID# 0048678

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (1,314)	10	1
2	Collection Expense	(6,290)	21	2
3	Amortization	(1,505)	36	3
4	PAC Dues	(13,611)	20	4
5	Non - Allowable Legal	(13,825)	19	5
6	Capitalized R&M	(12,183)	06	6
7	Building Co - State Income tax	(1,121)	21	7
8	Building Co - Misc. Expense	(358)	21	8
9	Building Co - Professional Fees	(4,826)	19	9
10	Building Co - Amortization	(17,681)	31	10
11	Building Co - Forgiveness of Loan	(1,218,340)	36	11
12	Misc. Income	(13,660)	21	12
13	Government Regulations	(3,833)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,308,548)		49

South Suburban Rehabilitation Center, Llc

ID# 0048678

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Rehabilitation Center, Llc **#** 0048678 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			228		12,184							12,412	1
2	Food Purchase	(164)		664									500	2
3	Housekeeping			1,375		172							1,547	3
4	Laundry													4
5	Heat and Other Utilities			1,703		193							1,896	5
6	Maintenance	(12,183)		4,690	10,062	332							2,901	6
7	Other (specify):*				7,648	1,706							9,354	7
8	**TOTAL General Services**	(12,347)		8,660	17,710	14,587							28,610	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,314)				54,953	(4,638)						49,001	10
10a	Therapy													10a
11	Activities													11
12	Social Services					43,870							43,870	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					13,839							13,839	15
16	**TOTAL Health Care and Programs**	(1,314)				112,662	(4,638)						106,710	16
	C. General Administration													
17	Administrative			3,510	20,180	107,604							131,294	17
18	Directors Fees													18
19	Professional Services	(22,484)	4,826	(359,232)		(120,225)	79						(497,036)	19
20	Fees, Subscriptions & Promotions	(36,564)		1,020		1,296							(34,248)	20
21	Clerical & General Office Expenses	(730,193)	1,479	10,085	126,217	29,008							(563,404)	21
22	Employee Benefits & Payroll Taxes				(26,357)								(26,357)	22
23	Inservice Training & Education													23
24	Travel and Seminar			44		1,584							1,628	24
25	Other Admin. Staff Transportation			1,138									1,138	25
26	Insurance-Prop.Liab.Malpractice			2,053		813							2,866	26
27	Other (specify):*				31,188	18,829							50,017	27
28	**TOTAL General Administration**	(789,241)	6,305	(341,382)	151,228	38,909	79						(934,102)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(802,902)	6,305	(332,722)	168,938	166,158	(4,559)						(798,782)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Suburban Rehabilitation Center, Llc **#** 0048678 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(38,156)	126,011	2,919		576							91,350	30
31	Amortization of Pre-Op. & Org.	(17,681)	17,681											31
32	Interest	(5,038)	415,840	18,280		210							429,292	32
33	Real Estate Taxes			5,129		640							5,769	33
34	Rent-Facility & Grounds		(780,000)										(780,000)	34
35	Rent-Equipment & Vehicles			1,257									1,257	35
36	Other (specify):*	(1,219,845)	1,218,340										(1,505)	36
37	**TOTAL Ownership**	(1,280,720)	997,872	27,585		1,426							(253,837)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(9,010)	(77)					(9,087)	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**						(9,010)	(77)					(9,087)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,083,623)	1,004,177	(305,137)	168,938	167,584	(13,569)	(77)					(1,061,706)	45

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	1,121	1,121	2
3	V	19	Professional Fees		Homewood Mercy Property, LLC	100.00%	4,826	4,826	3
4	V	33	RE Tax Expense	471,830	Homewood Mercy Property, LLC	100.00%	471,830		4
5	V	36	Forgiveness of Loan		Homewood Mercy Property, LLC	100.00%	1,218,340	1,218,340	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%	17,681	17,681	7
8	V	32	Interest Expense		Homewood Mercy Property, LLC	100.00%	415,840	415,840	8
9	V	21	Misc Expense		Homewood Mercy Property, LLC	100.00%	358	358	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,251,830			$ 2,256,007	$ * 1,004,177	14

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	664	664	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,375	1,375	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,703	1,703	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,690	4,690	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,510	3,510	20
21	V	19	Professional Fees	363,744	Extended Care Consulting, LLC	100.00%	4,512	(359,232)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,020	1,020	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,085	10,085	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	44	44	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,138	1,138	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,053	2,053	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,919	2,919	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	18,280	18,280	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,129	5,129	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,257	1,257	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			$ 58,607	$ * (305,137)	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	10,062	$ 10,062	15
16	V	06	Maintenance (Direct)	56,341	Extended Care Consulting, LLC	100.00%	56,341		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	933	933	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	6,715	6,715	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	20,180	20,180	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	126,217	126,217	22
23	V	21	Office and Clerical (Direct)	31,515	Extended Care Consulting, LLC	100.00%	31,515		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	28,287	28,287	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,901	2,901	25
26	V	22	Employee Benefits	26,357	Extended Care Consulting, LLC	100.00%		(26,357)	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			$ 114,213			$ 283,151	$ * 168,938	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 172	$ 172	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	193	193	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	332	332	17
18	V	19	Professional Fees	121,248	Extended Care Clinical, LLC	100.00%	1,023	(120,225)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,296	1,296	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,155	2,155	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,584	1,584	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	813	813	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	576	576	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	210	210	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	640	640	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	12,184	12,184	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,706	1,706	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	54,953	54,953	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	43,870	43,870	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	13,839	13,839	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	107,604	107,604	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	26,853	26,853	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	18,829	18,829	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,248			$ 288,832	$ * 167,584	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	56,150	MAC Rx, LLC	100.00%	51,512	(4,638)	15
16	V	10A	Therapy		MAC Rx, LLC	100.00%			16
17	V	19	Professional Services	(957)	MAC Rx, LLC	100.00%	(878)	79	17
18	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			18
19	V	22	Employee Benefits		MAC Rx, LLC	100.00%			19
20	V	39	Ancillary	109,082	MAC Rx, LLC	100.00%	100,072	(9,010)	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			$ 164,274			$ 150,705	$ * (13,569)	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary Expense	5,735	Reliable Medical of the Midwest, LLC	100.00%	5,658	$ (77)	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			$ 5,735			$ 5,658	$ * (77)	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 298,681	$ 298,681	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	298,681	CCS Employee Benefits Group	100.00%		(298,681)	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			$ 298,681			$ 298,681	$ *	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 PROPERT	HOMEWOOD	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	NURSING 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			LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	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			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1.33	3.22%	Alloc. Salary	$ 2,295	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.47	6.31%	Alloc Sal/Mgmt	12,609	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 14,904		13

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 5,451	$	61,689	$ 228	1
2	02	Food	Patient Days	1,476,506	37	15,903		61,689	664	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		61,689	1,375	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		61,689	1,703	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		61,689	4,690	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		61,689	3,510	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		61,689	4,512	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		61,689	1,020	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		61,689	10,085	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		61,689	44	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		61,689	1,138	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		61,689	2,053	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		61,689	2,919	13
14	32	Interest	Patient Days	1,476,506	37	437,528		61,689	18,280	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		61,689	5,129	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		61,689	1,257	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 58,607	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	240,841	240,841	61,689	10,062	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		56,341	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		61,689	933	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			6,715	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	61,689	20,180	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	61,689	126,217	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		31,515	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		61,689	28,287	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			2,901	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					$ 5,426,248	$ 4,601,481		$ 283,151	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	781,509	20	$ 2,174	$	61,689	$ 172	1
2	05	Utilities	Patient Days	781,509	20	2,440		61,689	193	2
3	06	Maintenance	Patient Days	781,509	20	4,212		61,689	332	3
4	19	Professional Fees	Patient Days	781,509	20	12,959		61,689	1,023	4
5	20	Dues and Subscriptions	Patient Days	781,509	20	16,422		61,689	1,296	5
6	21	Office & Clerical	Patient Days	781,509	20	27,302		61,689	2,155	6
7	24	Travel and Seminar	Patient Days	781,509	20	20,068		61,689	1,584	7
8	26	Insurance	Patient Days	781,509	20	10,303		61,689	813	8
9	30	Depreciation	Patient Days	781,509	20	7,302		61,689	576	9
10	32	Interest	Patient Days	781,509	20	2,656		61,689	210	10
11	33	Real Estate Taxes	Patient Days	781,509	20	8,112		61,689	640	11
12	01	Dietary Salary	Patient Days	781,509	20	154,359	154,359	61,689	12,184	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	781,509	20	21,616		61,689	1,706	13
14	10	Nursing Salary	Patient Days	781,509	20	696,174	696,174	61,689	54,953	14
15	12	Social Service Salary	Patient Days	781,509	20	555,767	555,767	61,689	43,870	15
16	15	Emp. Ben. - Healthcare	Patient Days	781,509	20	175,320		61,689	13,839	16
17	17	Administration Salary	Patient Days	781,509	20	1,363,182	1,363,182	61,689	107,604	17
18	21	Office Salary	Patient Days	781,509	20	340,193	340,193	61,689	26,853	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	781,509	20	238,538		61,689	18,829	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,659,098	$ 3,109,674		$ 288,832	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						51,512	1
2	10A	Therapy	Direct Allocation							2
3	19	Professional Services	Direct Allocation						(878)	3
4	21	Clerical & General Office Expense	Direct Allocation							4
5	22	Employee Benefits	Direct Allocation							5
6	39	Ancillary	Direct Allocation						100,072	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					$	$		$ 150,705	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Expense	Direct Allocation						5,658	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					$	$		$ 5,658	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 298,681	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					$	$		$ 298,681	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$ 7,793,615			$ 415,840	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from EC Clinical	X									210	6
7	Allocated from EC Consulting	X									18,280	7
8	See Supplemental Schedule							7,759,456			254,076	8
9	TOTAL Facility Related						$	$ 15,553,071			$ 688,406	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,038)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,038)	14
15	TOTALS (line 9+line14)						$	$ 15,553,071			$ 683,368	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 Rehabilitation Center, Llc **#** 0048678 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 533,984	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.)		$ 518,047	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,937)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 537,892	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.)		$ 18,251	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** $ 44,356 **For** ### **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 540,206	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	438,945	8
	2013	447,829	9
	2014	498,997	10
	2015	508,556	11
	2016	512,278	12

2017 Accrual = $512,278 x 1.05 = $537,892

Allocated from Extended Care Consulting = $5,129

Allocated from Extended Care Clinical = $640

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 512,277.95	$ 512,277.95
2.	See Attached	Allocated from Care Center Building	$ 181,041.32	$ 5,129.33
3.	See Attached	Allocated from Care Center Building	$ 181,041.32	$ 640.34
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 874,360.59	$ 518,047.62

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care Center Building			26,133	2
3	TOTALS			$ 255,008	3

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 1,227,204	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	32,656		20	911	911	23,813	9
10	Various			2008	35,282		20	2,042	2,042	20,117	10
11	Various			2009	29,244		20	1,330	1,330	14,503	11
12	Various			2010	36,366		20	1,460	1,460	18,977	12
13	Various			2011	151,861		20	7,073	7,073	71,817	13
14	Various			2012	138,638		20	6,537	6,537	47,470	14
15	Various			2013	526,107		20	54,330	54,330	241,670	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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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)		127,807	1,907		1,907		85,655	68
69	Financial Statement Depreciation			298,933			(298,933)		69
70	TOTAL (lines 4 thru 69)		$ 5,573,310	$ 426,851		$ 204,028	$ (222,823)	$ 1,751,227	70

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 5,573,310	$ 426,851		$ 204,028	$ (222,823)	$ 1,751,227	1
2	1650 Sf Roof	2014	6,350		20	635	635	2,487	2
3	2 Sets Of Solid Wood Doors	2014	8,652		20	865	865	3,245	3
4	2 10-Ton Rooftop A/C Units	2014	21,500		20	2,150	2,150	8,063	4
5	Sewage & Ground Water Pump System	2014	31,594		20	3,159	3,159	11,321	5
6	1 10-Ton Rooftop Unit	2014	9,975		20	998	998	3,491	6
7	Repair Work On Roof	2014	5,100		20	510	510	1,743	7
8	8 Panic Bars	2014	6,339		20	634	634	2,060	8
9	Concrete Walkway	2014	12,300		20	820	820	2,665	9
10	Toilet Exhaust Duct Fire Dampers	2014	80,000		20	8,000	8,000	25,333	10
11	New Circuit Breaker	2014	2,885		20	289	289	890	11
12	1St Floor Resident Room Wallpaper / Painting	2014	61,529		20	6,153	6,153	21,022	12
13	Stairwell Door Replacement	2014	10,350		20	1,035	1,035	3,278	13
14	Drywall 1St & 2Nd Floor And Corridors All Over Facility	2014	42,267		20	2,113	2,113	8,277	14
15	2Nd Floor Handrails & Crashrails	2014	23,900		20	1,195	1,195	4,680	15
16	Gutted & Rebuilt Shower Room - 1St Floor Spa	2014	79,000		20	3,950	3,950	15,471	16
17	Additional Labor For 2Nd Floor Dining Room Floor	2014	8,500		20	425	425	1,629	17
18	Floor Replacement - 1St Floor	2014	167,000		20	8,350	8,350	29,225	18
19	Repair 12 Doors, Repair Floor In Electrical/Maint Room	2014	4,360		20	218	218	709	19
20	Install Double Swing Gates In Stairwell	2014	4,500		20	225	225	750	20
21	Electric Door Replacement	2015	3,550		20	178	178	503	21
22	Landmark Construction Performed 1St Floor Resident Rooms	2015	48,471		20	2,424	2,424	6,867	22
23	Installation Of The Pit Ladder And Door Restrictor	2015	9,593		20	480	480	1,319	23
24	Landmark Construction - Swing Gates	2015	4,500		20	225	225	619	24
25	Landmark Construction- Center Flood Plain	2015	4,500		20	225	225	619	25
26	Electrical Work For Generator Installation	2015	130,000		20	6,500	6,500	17,875	26
27	Christy Webber- Landscaping Work	2015	9,000		20	450	450	1,125	27
28	Mallard Electric- Kohler Generator	2015	56,182		20	2,809	2,809	6,789	28
29	Christy Webber- Landscaping Work	2015	6,000		20	300	300	700	29
30	Seco Redige- Replace Compresor On Walk-In Freezer	2015	5,037		20	252	252	567	30
31	Kone, Inc- 2 Elevators	2015	205,000		20	10,250	10,250	22,208	31
32	Landmark Construction- Wardrobes (Wall Covering, Carpeting,	2015	57,000		20	2,850	2,850	6,175	32
33	Resident Rooms (100/200 Wing) - Wallcovering, Carpeting, Paint	2015	44,694		20	2,235	2,235	4,842	33
34	TOTAL (lines 1 thru 33)		$ 6,742,938	$ 426,851		$ 274,928	$ (151,923)	$ 1,967,771	34

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 6,742,938	$ 426,851		$ 274,928	$ (151,923)	$ 1,967,771	1
2	16 New Wood Doors	2015	9,506		20	475	475	990	2
3	Insurance Refund	2015	(75,000)		20	(3,750)	(3,750)	(9,688)	3
4	Wander Guard On 2 Doors	2016	5,004		20	250	250	500	4
5	Additional Work For Generator	2016	25,500		20	1,275	1,275	2,444	5
6	1 10-Ton Rooftop Unit (Out Of 12)	2016	10,250		20	513	513	940	6
7	Relocate Em Circuits	2016	2,741		20	137	137	274	7
8	New Generator Panel & Relocate Em Circuits	2016	9,980		20	499	499	998	8
9	Kitchen Exhaust Fan	2016	6,850		20	343	343	599	9
10	Repair Head Wall In 12 Rooms	2016	7,918		20	396	396	792	10
11	Elevator Work	2016	13,280		20	664	664	1,162	11
12	Asbestos Removal In Elevator	2016	4,000		20	200	200	317	12
13	Electrical Work For Elevator Rebuild	2016	16,340		20	817	817	1,089	13
14	Pump Out 2 Catch Basins, New 100 Gallon Grease Trap	2016	10,000		20	500	500	542	14
15	Walk-In Cooler Floor	2016	2,718		20	136	136	159	15
16	Elevator Work	2016	10,860		20	543	543	905	16
17	Replaced Sensors & Bottom Rollers On Automatic Door	2016	2,508		20	125	125	240	17
18	Sewage & Plumbing, Removed & Replaced Bad Pipes	2016	9,500		20	475	475	554	18
19	Kone Inc - 2 Elevators - Additional Cost	2017	5,095		20	510	510	510	19
20	Mechanical Room Elevator A/C Unit	2017	5,800		20	242	242	242	20
21	3.5 Ton Evaporator (100 Wing)	2017	8,750		20	522	522	522	21
22	3.5 Ton Evaporator (500 Wing)	2017	8,950		20	528	528	528	22
23	10-Ton A/C Rooftop Unit	2017	11,800		20	688	688	688	23
24	Smoke Hut	2017	5,800		20	242	242	242	24
25	10-Ton A/C Rooftop Unit	2017	11,800		20	295	295	295	25
26	3 Fire Doors	2017	5,086		20	170	170	170	26
27	Exhause Fan - 1St Floor Shower Room	2017	2,975		20	25	25	25	27
28	Cubicle Curtains	2017	2,606		20	130	130	130	28
29	Installed New Mixing Valve On Hot Water System	2017	3,976		20	199	199	199	29
30	Fire System Repair	2017	2,619		20	131	131	131	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,890,151	$ 426,851		$ 282,206	$ (144,645)	$ 1,974,269	34

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 6,890,151	$ 426,851		$ 282,206	$ (144,645)	$ 1,974,269	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)		$ 6,890,151	$ 426,851		$ 282,206	$ (144,645)	$ 1,974,269	34

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 6,890,151	$ 426,851		$ 282,206	$ (144,645)	$ 1,974,269	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)		$ 6,890,151	$ 426,851		$ 282,206	$ (144,645)	$ 1,974,269	34

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	32,016	821	35	821		12,553	3
4	Allocated from Extended Care Consulting-Dyer Bldg	2007	10,027	222	35	222		2,332	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,997	102	35	102		1,567	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	192	10	20	10		106	9
10	Allocated from Extended Care Consulting, LLC	2009	115	6	20	6		52	10
11	Allocated from Extended Care Consulting, LLC	2010	1,127	56	20	56		451	11
12	Allocated from Extended Care Consulting, LLC	2011	406	20	20	20		142	12
13	Allocated from Extended Care Consulting, LLC	2012	134	7	20	7		40	13
14	Allocated from Extended Care Consulting, LLC	2014	1,853	93	20	93		371	14
15	Allocated from Extended Care Consulting, LLC	2016	2,222	111	20	111		222	15
16									16
17	Allocated from Extended Care Consulting-Care Center Bldg	2002	26,447		20			26,447	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2003	31,167		20			31,167	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,549		20			1,549	19
20	Allocated from Extended Care Consulting-Care Center Bldg	2009	279	14	20	14		126	20
21	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,682	134	20	134		536	21
22	Allocated from Extended Care Consulting-Care Center Bldg	2015	441	22	20	22		143	22
23	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,740	87	20	87		174	23
24	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,019	151	20	151		151	24
25									25
26	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,302		20			3,302	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,891		20			3,891	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2005	193		20			193	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2009	35	2	20	2		16	29
30	Allocated from Extended Care Clinical - Care Center Bldg	2014	324	16	20	16		65	30
31	Allocated from Extended Care Clinical - Care Center Bldg	2015	55	3	20	3		18	31
32	Allocated from Extended Care Clinical - Care Center Bldg	2016	217	11	20	11		22	32
33	Allocated from Extended Care Clinical - Care Center Bldg	2017	377	19	20	19		19	33
34	TOTAL (lines 1 thru 33)		$ 127,807	$ 1,907		$ 1,907	$	$ 85,655	34

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 127,807	$ 1,907		$ 1,907	$	$ 85,655	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 127,807	$ 1,907		$ 1,907	$	$ 85,655	34

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 630,255	$ 952	$ 107,142	$ 106,190	10	$ 368,432	71
72	Current Year Purchases	2,982		298	298	10	298	72
73	Fully Depreciated Assets	1,301,486				10	1,301,486	73
74								74
75	TOTALS	$ 1,934,722	$ 952	$ 107,440	$ 106,488		$ 1,670,216	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Consulting		$ 7,540	$ 213	$ 213	$	5	$ 7,327	76
77		Allocated from Extended Care Clinical		4,055	423	423		5	4,055	77
78										78
79										79
80	TOTALS			$ 11,595	$ 636	$ 636	$		$ 11,382	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)	$ 9,091,476	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 428,439	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 390,283	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (38,156)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,655,867	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 5,829 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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$ 390,001	$		$ 390,001	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			156,919			156,919	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			408,812			408,812	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				10,420		10,420	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					15,904	49,338		65,242	13
14	TOTAL			$		$ 971,636	$ 59,758		$ 1,031,394	14

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

STATE OF ILLINOIS

Facility Name & ID Number South Suburban Rehabilitation Center, Llc **#** 0048678 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 7,176	$ 764,909	1
2	Cash-Patient Deposits	39,980	39,980	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,544,242	2,544,242	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	163,418	163,418	6
7	Other Prepaid Expenses	8,242	8,242	7
8	Accounts Receivable (owners or related parties)		304,878	8
9	Other(specify): See Attached Schedule	188,442	425,736	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,951,500	$ 4,251,405	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	1,943,156	1,943,156	15
16	Equipment, at Historical Cost	449,232	2,521,232	16
17	Accumulated Depreciation (book methods)	(1,159,040)	(5,129,751)	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	2,132	13,797	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,235,480	$ 3,291,325	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,186,980	$ 7,542,730	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,815,760	$ 3,535,759	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,367	50,367	28
29	Short-Term Notes Payable	7,759,456	7,759,456	29
30	Accrued Salaries Payable	299,989	299,989	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,348	20,348	31
32	Accrued Real Estate Taxes(Sch.IX-B)	537,892	537,892	32
33	Accrued Interest Payable		31,893	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	416,818	1,996,945	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,900,630	$ 14,232,649	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,793,615	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)**	$	$ 7,793,615	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,900,630	$ 22,026,264	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (8,713,650)	$ (14,483,534)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,186,980	$ 7,542,730	48

***(See instructions.)**

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,297,878)	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,297,876)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,415,774)	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)**	$ (1,415,774)	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)**	$ (8,713,650)	24 *

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,972,299	1
2	Discounts and Allowances for all Levels	(2,628,988)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,343,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,903,125	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,903,125	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	583,298	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,033	19
20	Radiology and X-Ray	5,875	20
21	Other Medical Services	13,953	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 632,159	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,038	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,038	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	58,016	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 58,016	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,941,649	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,963,208	31
32	Health Care	5,567,804	32
33	General Administration	3,448,389	33
	B. Capital Expense		
34	Ownership	1,855,272	34
	C. Ancillary Expense		
35	Special Cost Centers	1,031,394	35
36	Provider Participation Fee	491,356	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,357,423	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,415,774)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,415,774)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,055,586	44
45	Private Pay - Net Inpatient Revenue	592,659	45
46	Medicare - Net Inpatient Revenue	134,453	46
47	Other-(specify) Hospice	573,275	47
48	Other-(specify) Insurance	(12,662)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,343,311	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,749	1,936	$ 85,885	$ 44.36	1
2	Assistant Director of Nursing	782	759	29,064	38.29	2
3	Registered Nurses	18,322	19,396	697,428	35.96	3
4	Licensed Practical Nurses	53,499	57,904	1,741,252	30.07	4
5	CNAs & Orderlies	64,231	68,199	797,410	11.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,171	12,883	245,176	19.03	8
9	Activity Director	1,916	2,170	40,132	18.49	9
10	Activity Assistants	15,407	16,457	194,033	11.79	10
11	Social Service Workers	11,508	12,283	271,898	22.14	11
12	Dietician					12
13	Food Service Supervisor	2,104	2,226	41,290	18.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,546	27,699	303,616	10.96	15
16	Dishwashers					16
17	Maintenance Workers	5,706	6,266	108,447	17.31	17
18	Housekeepers	30,349	32,828	355,425	10.83	18
19	Laundry	4,284	4,826	58,620	12.15	19
20	Administrator	2,038	2,296	96,988	42.23	20
21	Assistant Administrator	861	857	24,039	28.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,686	7,277	121,167	16.65	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	3,457	3,950	55,238	13.98	31
32	Other Health Care(specify)					32
33	Other(specify)	11,178	11,782	145,723	12.37	33
34	TOTAL (lines 1 - 33)	270,794	291,995	$ 5,412,831 *	$ 18.54	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	817	$ 42,470	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	13,689	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	15,250	10-03	47
48					48
49	TOTAL (lines 35 - 48)	817	$ 131,409		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	31,552	834,599	10-03	52
53	TOTAL (lines 50 - 52)	31,552	$ 834,599		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nikki Dinsmore	Administrator	0	$ 26,222
Nichole Cole	Administrator	0	70,766
Owens, Latayna	Asst. Admin	0	24,039
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,027

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
Ability Network	Data processing	$ 150
Matrixcare	Billing Software	30,757
National Datacase Corporation	Data processing	2,316
Paycor Fee	Data processing	30,367
ECC Consulting	Home Office Expense	363,744
ECC Clinical	Home Office Expense	121,248
Marcum LLP	Accounting	24,550
See attached	Legal Fees	22,963
Personnel Planners	Unemployment Tax Cons.	1,668
Blymas	Tax Credit Service	6,000
Kellerher Helmrich	Regulatory Compliance	689
See Supplemental Schedule		26,708
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 631,160

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 252,040
Unemployment Compensation Insurance	133,765
FICA Taxes	410,943
Employee Health Insurance	280,176
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	10,221
Other Employee Welfare	16,359
Holiday Expense	7,085
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,110,589

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	28,402
Health Care Worker Background Check	
(Indicate # of checks performed 330)	5,383
Patient Background Checks	
Dues & Subscriptions	33,294
Licenses & Fees	3,993
Allocated from EC Consulting	1,020
Allocated from EC Clinical	1,296
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 75,378

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,460
Allocated from EC Consulting	44
Allocated from EC Clinical	1,584
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,088

* Attach copy of IMRF notifications

**See instructions.

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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. $ **67,631** 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. $ **491,356**
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? **100% line 1**
d. Have vehicle usage logs been maintained?
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