		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0048678

Facility Name: South Suburban Rehabilitation Center, Llc Ctr

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	45,390	2,127	4,187	51,704	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,390	2,127	4,187	51,704	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.69%

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 3,430

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc C # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	337,818	89,163	42,213	469,194		469,194	14,751	483,945			1
2	Food Purchase		348,501		348,501		348,501	325	348,826			2
3	Housekeeping	368,023	34,520		402,543		402,543	1,408	403,951			3
4	Laundry	33,628	30,746		64,374		64,374		64,374			4
5	Heat and Other Utilities			258,867	258,867		258,867	2,083	260,950			5
6	Maintenance	82,063		292,673	374,736		374,736	(6,501)	368,235			6
7	Other (specify):*							7,109	7,109			7
8	**TOTAL General Services**	821,532	502,930	593,753	1,918,215		1,918,215	19,175	1,937,390			8
	B. Health Care and Programs											
9	Medical Director			59,623	59,623		59,623		59,623			9
10	Nursing and Medical Records	3,936,533	345,009	419,584	4,701,126		4,701,126	52,480	4,753,606			10
10a	Therapy	256,273		5,468	261,741		261,741		261,741			10a
11	Activities	252,332	34,154		286,486		286,486		286,486			11
12	Social Services	320,433			320,433		320,433	41,300	361,733			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	665			665		665	14,055	14,720			15
16	**TOTAL Health Care and Programs**	4,766,236	379,163	484,675	5,630,074		5,630,074	107,835	5,737,909			16
	C. General Administration											
17	Administrative	148,132			148,132		148,132	138,913	287,045			17
18	Directors Fees											18
19	Professional Services			652,513	652,513	(41,402)	611,111	(477,629)	133,482			19
20	Dues, Fees, Subscriptions & Promotions			147,429	147,429		147,429	(45,385)	102,044			20
21	Clerical & General Office Expenses	120,200	32,986	1,023,747	1,176,933		1,176,933	(737,668)	439,265			21
22	Employee Benefits & Payroll Taxes			1,026,832	1,026,832		1,026,832	(17,906)	1,008,926			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,000	3,000		3,000	1,488	4,488			24
25	Other Admin. Staff Transportation			10,839	10,839		10,839	1,152	11,991			25
26	Insurance-Prop.Liab.Malpractice			869,459	869,459		869,459	2,343	871,802			26
27	Other (specify):*							55,342	55,342			27
28	**TOTAL General Administration**	268,332	32,986	3,733,819	4,035,137	(41,402)	3,993,735	(1,079,350)	2,914,386			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,856,100	915,079	4,812,247	11,583,426	(41,402)	11,542,024	(952,340)	10,589,685			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 Ctr #0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			283,119	283,119		283,119	94,204	377,323			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			484,677	484,677		484,677	388,174	872,851			32
33	Real Estate Taxes			579,237	579,237	41,402	620,639	6,226	626,865			33
34	Rent-Facility & Grounds			780,000	780,000		780,000	(780,000)				34
35	Rent-Equipment & Vehicles			6,972	6,972		6,972	574	7,546			35
36	Other (specify):*			1,505	1,505		1,505	(1,505)				36
37	**TOTAL Ownership**			2,135,510	2,135,510	41,402	2,176,912	(292,327)	1,884,585			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		234,620	986,664	1,221,284		1,221,284	(12,335)	1,208,949			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			471,198	471,198		471,198		471,198			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		234,620	1,457,862	1,692,482		1,692,482	(12,335)	1,680,147			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,856,100	1,149,699	8,405,619	15,411,418		15,411,418	(1,257,002)	14,154,416			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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(35,022)	30		9
10	Interest and Other Investment Income	(10,479)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(142)	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	(887,435)	21		24
25	Fund Raising, Advertising and Promotional	(28,814)	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	(107,626)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,069,518)		$	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)	(187,484)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (187,484)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,257,002)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

South Suburban Rehabilitation Center, Llc Ctr

ID# 0048678

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (510)	10	1
2	Political Donations	(500)	20	2
3	Theft Loss	(261)	21	3
4	Collection Expense	(10,312)	21	4
5	Amortization	(1,505)	36	5
6	Bldg Co - State Replacement Tax	(10,386)	21	6
7	Bldg Co - Filing Fee	(75)	21	7
8	Bldg Co - Bank Charges	(36)	21	8
9	Bldg Co - Amortization	(16,215)	36	9
10	Capitalized R&M	(22,117)	06	10
11	PAC Dues	(19,529)	20	11
12	Non-Allowabe Dues	(129)	20	12
13	Professional Fees - Lobbying	(319)	19	13
14	Duplicate Expense	(25,732)	21	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**	(107,626)		49

South Suburban Rehabilitation Center, Llc Ctr

ID# 0048678

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			229		14,522							14,751	1
2	Food Purchase	(142)		467									325	2
3	Housekeeping			1,247		161							1,408	3
4	Laundry													4
5	Heat and Other Utilities			1,864		219							2,083	5
6	Maintenance	(22,117)		4,992	10,545	79							(6,501)	6
7	Other (specify):*				5,070	2,039							7,109	7
8	**TOTAL General Services**	(22,259)		8,799	15,615	17,020							19,175	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(510)				58,806	(5,816)						52,480	10
10a	Therapy													10a
11	Activities													11
12	Social Services					41,300							41,300	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					14,055							14,055	15
16	**TOTAL Health Care and Programs**	(510)				114,161	(5,816)						107,835	16
	C. General Administration													
17	Administrative			1,788	20,536	116,589							138,913	17
18	Directors Fees													18
19	Professional Services	(319)		(357,220)		(120,090)							(477,629)	19
20	Fees, Subscriptions & Promotions	(48,972)		2,293		1,294							(45,385)	20
21	Clerical & General Office Expenses	(934,237)	10,497	11,766	134,482	39,824							(737,668)	21
22	Employee Benefits & Payroll Taxes				(17,906)								(17,906)	22
23	Inservice Training & Education													23
24	Travel and Seminar			435		1,053							1,488	24
25	Other Admin. Staff Transportation			1,152									1,152	25
26	Insurance-Prop.Liab.Malpractice			2,095		248							2,343	26
27	Other (specify):*				33,753	21,589							55,342	27
28	**TOTAL General Administration**	(983,528)	10,497	(337,691)	170,865	60,507							(1,079,350)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,006,297)	10,497	(328,892)	186,480	191,688	(5,816)						(952,340)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(35,022)	126,011	3,045		170							94,204	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(10,479)	372,344	26,115		194							388,174	32
33	Real Estate Taxes			5,513		713							6,226	33
34	Rent-Facility & Grounds		(780,000)										(780,000)	34
35	Rent-Equipment & Vehicles			574									574	35
36	Other (specify):*	(17,720)	16,215										(1,505)	36
37	**TOTAL Ownership**	(63,221)	(265,430)	35,247		1,077							(292,327)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(12,335)						(12,335)	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**						(12,335)						(12,335)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,069,518)	(254,933)	(293,645)	186,480	192,765	(18,151)						(1,257,002)	45

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$	$ (780,000)	1
2	V	33	RE Tax Expense	579,237	Homewood Mercy Property, LLC		579,237		2
3	V	21	State Replacement Tax		Homewood Mercy Property, LLC		10,386	10,386	3
4	V	21	Filing Fee		Homewood Mercy Property, LLC		75	75	4
5	V	21	Bank Charges		Homewood Mercy Property, LLC		36	36	5
6	V	30	Depreciation		Homewood Mercy Property, LLC		126,011	126,011	6
7	V	36	Amortization		Homewood Mercy Property, LLC		16,215	16,215	7
8	V	32	Interest		Homewood Mercy Property, LLC		372,344	372,344	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,359,237			$ 1,104,304	$ * (254,933)	14

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 229	$ 229	15
16	V	02	Food		Extended Care Consulting, LLC		467	467	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,247	1,247	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,864	1,864	18
19	V	06	Maintenance		Extended Care Consulting, LLC		4,992	4,992	19
20	V	17	Administrative		Extended Care Consulting, LLC		1,788	1,788	20
21	V	19	Professional Fees	363,744	Extended Care Consulting, LLC		6,524	(357,220)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,293	2,293	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		11,766	11,766	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		435	435	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		1,152	1,152	25
26	V	26	Insurance		Extended Care Consulting, LLC		2,095	2,095	26
27	V	30	Depreciation		Extended Care Consulting, LLC		3,045	3,045	27
28	V	32	Interest		Extended Care Consulting, LLC		26,115	26,115	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		5,513	5,513	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		574	574	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			$ 70,099	$ * (293,645)	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		10,545	$ 10,545	15
16	V	06	Maintenance (Direct)	25,985	Extended Care Consulting, LLC		25,985		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC		915	915	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC		4,155	4,155	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC		20,536	20,536	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC		134,482	134,482	22
23	V	21	Office and Clerical (Direct)	33,701	Extended Care Consulting, LLC		33,701		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC		31,000	31,000	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC		2,753	2,753	25
26	V	22	Employee Benefits	17,906	Extended Care Consulting, LLC			(17,906)	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			$ 77,592			$ 264,072	$ * 186,480	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%	$ 161	$ 161	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	219	219	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	79	79	17
18	V	19	Professional Fees	121,248	Extended Care Clinical, LLC	100.00%	1,158	(120,090)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,294	1,294	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,650	2,650	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,053	1,053	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	248	248	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	170	170	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	194	194	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	713	713	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	14,522	14,522	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	2,039	2,039	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	58,806	58,806	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	41,300	41,300	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	14,055	14,055	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	116,589	116,589	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	37,174	37,174	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	21,589	21,589	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,248			$ 314,013	$ * 192,765	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	67,483	MAC Rx, LLC		61,667	(5,816)	15
16	V	39	Ancillary	143,117	MAC Rx, LLC		130,782	(12,335)	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			$ 210,600			$ 192,450	$ * (18,151)	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 265,126	$ 265,126	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	265,126	CCS Employee Benefits Group			(265,126)	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			$ 265,126			$ 265,126	$ *	39

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	HOMEWOOD MERCY PROPERTIES, LLC		BUILDING COMPANY	1
2	GALE ROTHNER	49.00%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			NAPERVILLE MANOR HEALTH & REHAB CENTER	NAPERVILLE				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			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				20
21			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				21
22			SPRING CREEK NURSING & REHAB CENTER	JOLIET				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			THE PARC AT JOLIET	JOLIET				25
26			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				26
27			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				27
28								28
29								29
30								30

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	1.26	3.15%	Alloc. Salary	$ 2,384	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.17	2.13%	Alloc Sal/Mgmt	9,756	9756	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	$ 12,140		13

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,389,746	40	$ 5,386	$	59,175	$ 229	1
2	02	Food	Patient Days	1,389,746	40	10,961		59,175	467	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295		59,175	1,247	3
4	05	Utilities	Patient Days	1,389,746	40	43,781		59,175	1,864	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234		59,175	4,992	5
6	17	Administrative	Patient Days	1,389,746	40	42,000		59,175	1,788	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207		59,175	6,524	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847		59,175	2,293	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330		59,175	11,766	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217		59,175	435	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054		59,175	1,152	11
12	26	Insurance	Patient Days	1,389,746	40	49,193		59,175	2,095	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516		59,175	3,045	13
14	32	Interest	Patient Days	1,389,746	40	613,328		59,175	26,115	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471		59,175	5,513	15
16	35	Rent - Equipment	Patient Days	1,389,746	40	13,470		59,175	574	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,646,291	$		$ 70,099	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,389,746	40	247,664	247,664	59,175	10,545	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298		25,985	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		59,175	915	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140			4,155	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	59,175	20,536	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	59,175	134,482	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472		33,701	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		59,175	31,000	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742			2,753	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					$ 5,599,498	$ 4,730,091		$ 264,072	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	710,509	22	$ 1,936	$	59,175	$ 161	1
2	05	Utilities	Patient Days	710,509	22	2,630		59,175	219	2
3	06	Maintenance	Patient Days	710,509	22	952		59,175	79	3
4	19	Professional Fees	Patient Days	710,509	22	13,906		59,175	1,158	4
5	20	Dues and Subscriptions	Patient Days	710,509	22	15,540		59,175	1,294	5
6	21	Office & Clerical	Patient Days	710,509	22	31,816		59,175	2,650	6
7	24	Travel and Seminar	Patient Days	710,509	22	12,645		59,175	1,053	7
8	26	Insurance	Patient Days	710,509	22	2,983		59,175	248	8
9	30	Depreciation	Patient Days	710,509	22	2,046		59,175	170	9
10	32	Interest	Patient Days	710,509	22	2,330		59,175	194	10
11	33	Real Estate Taxes	Patient Days	710,509	22	8,555		59,175	713	11
12	01	Dietary Salary	Patient Days	710,509	22	174,364	174,364	59,175	14,522	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	710,509	22	24,481		59,175	2,039	13
14	10	Nursing Salary	Patient Days	710,509	22	706,073	706,073	59,175	58,806	14
15	12	Social Service Salary	Patient Days	710,509	22	495,889	495,889	59,175	41,300	15
16	15	Emp. Ben. - Healthcare	Patient Days	710,509	22	168,758		59,175	14,055	16
17	17	Administration Salary	Patient Days	710,509	22	1,399,873	1,399,873	59,175	116,589	17
18	21	Office Salary	Patient Days	710,509	22	446,345	446,345	59,175	37,174	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	710,509	22	259,213		59,175	21,589	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,770,337	$ 3,222,544		$ 314,013	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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						61,667	1
2	39	Ancillary	Direct Allocation						130,782	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					$	$		$ 192,450	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 265,126	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					$	$		$ 265,126	25

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ct # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Atied		X	Loan Payable			$	$ 3,900,188			$ 372,344	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	Line of Credit				9,817,525			484,677	6
7	Allocated from EC Clinical	X									194	7
8	Allocated from EC Consulting	X									26,115	8
9	TOTAL Facility Related						$	$ 13,717,713			$ 883,330	9
	B. Non-Facility Related*											
10	Interest Income		X								(10,479)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,479)	14
15	TOTALS (line 9+line14)						$	$ 13,717,713			$ 872,851	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	537,892	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.)	$	551,167	2
3. Under or (over) accrual (line 2 minus line 1).	$	13,275	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	572,188	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.)**	$	41,402	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** $ 45,609 **For** 2013,2014 ,2015 **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.	$	626,864	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	447,829	8
	2014	498,997	9
	2015	508,556	10
	2016	512,278	11
	2017	544,941	12

2018 Accrual = $544,941 x 1.05 = $572,188 (Rounded)
Allocated from Extended Care Consulting = $5,513
Allocated from Extended Care Clinical = $713

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center, Llc Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (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 2017 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 2017.

	(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	$ 544,940.54	$ 544,940.54
2.	See Attached	Allocated from Care Center Building	$ 190,923.89	$ 5,512.82
3.	See Attached	Allocated from Care Center Building	$ 190,923.89	$ 712.50
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 926,788.32	$ 551,165.86

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center, Llc Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			26,737	2
3	TOTALS			$ 255,612	3

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,355,643	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	32,656		20	911	911	24,724	9
10	Various			2008	35,282		20	2,042	2,042	22,158	10
11	Various			2009	29,244		20	1,330	1,330	15,833	11
12	Various			2010	36,366		20	1,460	1,460	20,438	12
13	Various			2011	151,861		20	7,073	7,073	78,890	13
14	Various			2012	138,638		20	6,537	6,537	54,006	14
15	Various			2013	526,107		20	50,484	50,484	292,154	15
16	Various			2014	586,101		20	41,724	41,724	188,062	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		132,290	2,028		2,028		89,677	68
69	Financial Statement Depreciation			283,119			(283,119)		69
70	TOTAL (lines 4 thru 69)		$ 6,163,893	$ 411,158		$ 242,026	$ (169,132)	$ 2,141,584	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 6,163,893	$ 411,158		$ 242,026	$ (169,132)	$ 2,141,584	1
2	Electric Door Replacement	2015	3,550		20	178	178	680	2
3	Landmark Construction Performed 1St Floor Resident Rooms	2015	48,471		20	2,424	2,424	9,290	3
4	Installation Of The Pit Ladder And Door Restrictor	2015	9,593		20	480	480	1,799	4
5	Landmark Construction - Swing Gates	2015	4,500		20	225	225	844	5
6	Landmark Construction- Center Flood Plain	2015	4,500		20	225	225	844	6
7	Electrical Work For Generator Installation	2015	130,000		20	6,500	6,500	24,375	7
8	Mallard Electric- Kohler Generator	2015	56,182		20	2,809	2,809	9,598	8
9	Christy Webber- Landscaping Work	2015	6,000		20	300	300	1,000	9
10	Seco Redige- Replace Compresor On Walk-In Freezer	2015	5,037		20	252	252	819	10
11	Kone, Inc- 2 Elevators	2015	205,000		20	10,250	10,250	32,458	11
12	Landmark Construction- Wardrobes (Wall Covering, Carpeting, P	2015	57,000		20	2,850	2,850	9,025	12
13	Resident Rooms (100/200 Wing) - Wallcovering, Carpeting, Paint	2015	44,694		20	2,235	2,235	7,077	13
14	16 New Wood Doors	2015	9,506		20	475	475	1,466	14
15	Insurance Refund	2015	(75,000)		20	(3,750)	(3,750)	(13,438)	15
16	Relocate Em Circuits	2015	2,741		20	137	137	411	16
17	New Generator Panel & Relocate Em Circuits	2015	9,980		20	499	499	1,497	17
18	Repair Head Wall In 12 Rooms	2015	7,918		20	396	396	1,188	18
19	Wander Guard On 2 Doors	2016	5,004		20	250	250	751	19
20	Additional Work For Generator	2016	25,500		20	1,275	1,275	3,719	20
21	1 10-Ton Rooftop Unit (Out Of 12)	2016	10,250		20	513	513	1,452	21
22	Kitchen Exhaust Fan	2016	6,850		20	343	343	942	22
23	Elevator Work	2016	13,280		20	664	664	1,826	23
24	Asbestos Removal In Elevator	2016	4,000		20	200	200	517	24
25	Electrical Work For Elevator Rebuild	2016	16,340		20	817	817	1,906	25
26	Pump Out 2 Catch Basins, New 100 Gallon Grease Trap	2016	10,000		20	500	500	1,042	26
27	Walk-In Cooler Floor	2016	2,718		20	136	136	294	27
28	Elevator Work	2016	10,860		20	543	543	1,448	28
29	Replaced Sensors & Bottom Rollers On Automatic Door	2016	2,508		20	125	125	366	29
30	Sewage & Plumbing, Removed & Replaced Bad Pipes	2016	9,500		20	475	475	1,029	30
31	Kone Inc. - 2 Elevators	2017	5,095		20	510	510	1,019	31
32	Mechanical Room Elevator A/C Unit	2017	5,800		20	290	290	532	32
33	3.5 Ton Evaporator (100 Wing)	2017	8,750		20	438	438	693	33
34	TOTAL (lines 1 thru 33)		$ 6,830,021	$ 411,158		$ 275,587	$ (135,571)	$ 2,248,051	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 6,830,021	$ 411,158		$ 275,587	$ (135,571)	$ 2,248,051	1
2	3.5 Ton Evaporator (500 Wing)	2017	8,950		20	448	448	709	2
3	10-Ton A/C Rooftop Unit	2017	11,800		20	590	590	934	3
4	Smoke Hut	2017	5,800		20	290	290	411	4
5	10-Ton A/C Rooftop Unit	2017	11,800		20	590	590	738	5
6	3 Fire Doors	2017	5,086		20	254	254	339	6
7	Exhause Fan - 1St Floor Shower Room	2017	2,975		20	149	149	174	7
8	Cubicle Curtains	2017	2,606		20	130	130	228	8
9	Installed New Mixing Valve On Hot Water System	2017	3,976		20	199	199	348	9
10	Fire System Repair	2017	2,619		20	131	131	251	10
11	Install New Water Heater And New Electrical Circuit System	2018	3,200		20	107	107	107	11
12	Replaced 5 Fire/Smoke Damper Actuators,3 Thermal Links	2018	3,340		20	167	167	167	12
13	Parking Lot Piping - Remove/Replace Catch Basin	2018	6,564		20	328	328	328	13
14	Installation Of Mechanical Shutoff Gas Valve, Piping, Wiring	2018	3,155		20	158	158	158	14
15	Boiler Repair - Main Pump, Pump Motor	2018	2,818		20	282	282	282	15
16	800Btu Window Mounted Air Conditioner	2018	3,710		20	185	185	185	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)		$ 6,908,420	$ 411,158		$ 279,595	$ (131,563)	$ 2,253,408	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 6,908,420	$ 411,158		$ 279,595	$ (131,563)	$ 2,253,408	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		$ 6,908,420	$ 411,158		$ 279,595	$ (131,563)	$ 2,253,408	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 6,908,420	$ 411,158		$ 279,595	$ (131,563)	$ 2,253,408	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
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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)		$ 6,908,420	$ 411,158		$ 279,595	$ (131,563)	$ 2,253,408	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	32,628	837	35	837		13,630	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	10,219	226	35	226		2,603	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	4,217	108	35	108		1,762	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	26,953		20			26,953	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	31,764		20			31,764	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,578		20			1,578	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	285	14	20	14		142	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,733	137	20	137		683	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	449	22	20	22		194	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,774	89	20	89		266	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,076	154	20	154		308	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,410	71	20	71		71	16
17	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,484		20			3,484	17
18	Allocated from Extended Care Clinical - Care Center Bldg	2003	4,105		20			4,105	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2005	204		20			204	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2009	37	2	20	2		18	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2014	342	17	20	17		86	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2015	58	3	20	3		25	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2016	229	11	20	11		34	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2017	398	20	20	20		40	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2018	182	9	20	9		9	25
26	Allocated from Extended Care Consulting	2007	196	10	20	10		118	26
27	Allocated from Extended Care Consulting	2009	117	6	20	6		59	27
28	Allocated from Extended Care Consulting	2010	1,149	57	20	57		517	28
29	Allocated from Extended Care Consulting	2011	413	21	20	21		166	29
30	Allocated from Extended Care Consulting	2012	136	7	20	7		48	30
31	Allocated from Extended Care Consulting	2014	1,888	94	20	94		472	31
32	Allocated from Extended Care Consulting	2016	2,264	113	20	113		340	32
33									33
34	TOTAL (lines 1 thru 33)		$ 132,290	$ 2,028		$ 2,028	$	$ 89,677	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 132,290	$ 2,028		$ 2,028	$	$ 89,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 132,290	$ 2,028		$ 2,028	$	$ 89,677	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 630,401	$ 971	$ 97,259	$ 96,289	10	$ 462,810	71
72	Current Year Purchases	2,530		253	253	10	253	72
73	Fully Depreciated Assets	1,306,999				10	1,306,999	73
74								74
75	TOTALS	$ 1,939,931	$ 971	$ 97,512	$ 96,542		$ 1,770,062	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		Alloc. Extended Care Clinical	2012	$ 4,279	$	$	$	5	$ 4,279	76
77		Alloc. Extended Care Consulting	2014	1,084	217	217	0	5	1,084	77
78										78
79										79
80	TOTALS			$ 5,363	$ 217	$ 217	$ 0		$ 5,363	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)	$ 9,109,326	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 412,346	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 377,324	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,022)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,028,834	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 7,546 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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$		$ 424,067	$		$ 424,067	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			180,870			180,870	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			376,510			376,510	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				190,664		190,664	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					5,217	43,956		49,173	13
14	TOTAL			$		$ 986,664	$ 234,620		$ 1,221,284	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 Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 2,166	$ 2,166	1
2	Cash-Patient Deposits	54,408	54,408	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,097,796	2,097,796	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	158,225	158,225	6
7	Other Prepaid Expenses	9,263	9,263	7
8	Accounts Receivable (owners or related parties)		304,878	8
9	Other(specify): See Attached Schedule	132,302	132,302	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,454,160	$ 2,759,038	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	1,946,356	1,946,356	15
16	Equipment, at Historical Cost	449,232	2,521,232	16
17	Accumulated Depreciation (book methods)	(1,442,159)	(5,538,881)	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	627	627	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 954,056	$ 2,872,225	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,408,216	$ 5,631,263	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,053,792	$ 3,773,793	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,271	59,271	28
29	Short-Term Notes Payable	9,817,525	9,817,525	29
30	Accrued Salaries Payable	355,599	355,599	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,923	26,923	31
32	Accrued Real Estate Taxes(Sch.IX-B)	572,188	572,188	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	350,734	4,463,993	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 15,236,032	$ 19,069,292	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,900,188	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)**	$	$ 3,900,188	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,236,032	$ 22,969,480	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (11,827,816)	$ (17,338,217)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,408,216	$ 5,631,263	48

*(See instructions.)

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (8,713,650)	1
2	Restatements (describe):		2
3	**Bad Debt Expense**	100,000	3
4	**Rounding**	(1)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (8,613,651)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,214,165)	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)**	$ (3,214,165)	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)**	$ (11,827,816)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,581,111	1
2	Discounts and Allowances for all Levels	(2,356,137)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,224,974	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,730,290	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,730,290	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	146,940	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,458	19
20	Radiology and X-Ray	5,850	20
21	Other Medical Services	9,594	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 186,842	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,479	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,479	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	44,668	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,668	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,197,253	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,918,215	31
32	Health Care	5,630,074	32
33	General Administration	4,035,137	33
	B. Capital Expense		
34	Ownership	2,135,510	34
	C. Ancillary Expense		
35	Special Cost Centers	1,221,284	35
36	Provider Participation Fee	471,198	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,411,418	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,214,165)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,214,165)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,223,747	44
45	Private Pay - Net Inpatient Revenue	414,215	45
46	Medicare - Net Inpatient Revenue	184,852	46
47	Other-(specify) Hospice	535,650	47
48	Other-(specify) Insurance	(133,490)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,224,974	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	1,981	2,154	$ 111,579	$ 51.80	1
2	Assistant Director of Nursing	1,928	2,171	71,961	33.15	2
3	Registered Nurses	11,276	11,800	441,714	37.43	3
4	Licensed Practical Nurses	56,326	60,001	1,834,127	30.57	4
5	CNAs & Orderlies	91,677	98,608	1,346,395	13.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,227	13,561	256,273	18.90	8
9	Activity Director	1,925	2,165	40,717	18.81	9
10	Activity Assistants	15,832	17,159	211,615	12.33	10
11	Social Service Workers	13,580	14,736	320,433	21.74	11
12	Dietician					12
13	Food Service Supervisor	1,990	2,171	40,245	18.54	13
14	Head Cook	5,572	5,927	77,312	13.04	14
15	Cook Helpers/Assistants	18,633	20,221	220,261	10.89	15
16	Dishwashers					16
17	Maintenance Workers	4,059	4,444	82,063	18.47	17
18	Housekeepers	29,670	32,341	368,023	11.38	18
19	Laundry	2,976	3,230	33,628	10.41	19
20	Administrator	2,013	2,156	104,435	48.44	20
21	Assistant Administrator	1,404	1,508	43,697	28.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,558	7,373	120,200	16.30	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	3,045	3,369	48,724	14.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,922	4,309	82,698	19.19	33
34	TOTAL (lines 1 - 33)	286,594	309,404	$ 5,856,100 *	$ 18.93	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	812	$ 42,213	01-03	35
36	Medical Director	Monthly	59,623	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,114	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	5,468	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatrist	Monthly	6,250	10-03	47
48					48
49	TOTAL (lines 35 - 48)	812	$ 126,668		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	15,131	400,220	10-03	52
53	TOTAL (lines 50 - 52)	15,131	$ 400,220		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Coralette Bowling	Administrator	0	$ 35,008
Nichole Cole	Administrator	0	16,033
Sherri Mitchell	Administrator	0	53,393
Latayna Owens	Assistant Admin	0	43,697
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,131

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
Personnel Planners	Unemployment Consulting	$ 2,586
Marcum LLP	Accounting	25,850
ECC Consulting	Home Office Expense	363,744
ECC Clinical	Home Office Expense	121,248
Paycor Fee	Payroll Solutions	32,955
National Datacare Corporation	Data Processing	2,610
Matrixcare	Billing Software	33,155
See Attached	Legal Fees	12,838
Skidelsky & Associates	Tax Appeal Service	41,018
Pinnacle Quality	Customer Satisfaction	2,554
Legat Architects	Architectual Services	524
See Supplemental Schedule		13,430
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 652,513

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 194,565
Unemployment Compensation Insurance	115,817
FICA Taxes	443,338
Employee Health Insurance	222,361
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,356
Pension Expense	8,430
Other Employee Welfare	20,003
Holiday Expense	3,056
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,008,926

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	54,327
Health Care Worker Background Check	
(Indicate # of checks performed 53)	4,133
Patient Background Checks	
Dues & Subscriptions	29,913
Licenses & Fees	8,094
Allocated from EC Consulting	2,293
Allocated from EC Clinical	1,294
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 102,044

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,000
Allocated from EC Consulting	435
Allocated from EC Clinical	1,053
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,488

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number South Suburban Rehabilitation Center, Llc Ctr # 0048678 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **HCCI - $39,057**

(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. $ **80,455** 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. $ **471,198**
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% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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