		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0048678

Facility Name: South Suburban Rehab Center

Address: 19000 S Halsted St (Number) Homewood (City) 60430 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2007

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	** Subject to the attached Accountants' Consulting Report*	
	(Print Name and Title)	
	(Firm Name & Address)	Marcum, LLP 9 Parkway North, Suite 200 Deerfield, IL 60015
	(Telephone)	(847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	32,123	787	9,190	42,100	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,123	787	9,190	42,100	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.41%

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 1/1/2007

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 259 and days of care provided 3,349

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	391,052	75,444	47,921	514,417		514,417	1,025	515,442			1
2	Food Purchase		357,968		357,968		357,968	71	358,039			2
3	Housekeeping	291,670	67,314		358,984		358,984	1,877	360,861			3
4	Laundry	22,235	29,361	1,062	52,658		52,658		52,658			4
5	Heat and Other Utilities			229,808	229,808		229,808	(22,619)	207,189			5
6	Maintenance	130,628	75	234,499	365,202		365,202	4,919	370,121			6
7	Other (specify):*							5,113	5,113			7
8	**TOTAL General Services**	835,585	530,162	513,290	1,879,037		1,879,037	(9,614)	1,869,423			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	4,598,157	374,815	656,065	5,629,037		5,629,037	32,342	5,661,379			10
10a	Therapy	241,454		7,034	248,488		248,488		248,488			10a
11	Activities	220,575	8,046	594	229,215		229,215		229,215			11
12	Social Services	186,305	48	1,155	187,508		187,508	21,910	209,418			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	30,384			30,384		30,384	10,170	40,554			15
16	**TOTAL Health Care and Programs**	5,276,875	382,909	700,848	6,360,632		6,360,632	64,422	6,425,054			16
	C. General Administration											
17	Administrative	278,680			278,680		278,680	163,253	441,933			17
18	Directors Fees											18
19	Professional Services			689,952	689,952	(22,106)	667,846	(513,789)	154,057			19
20	Dues, Fees, Subscriptions & Promotions			250,556	250,556		250,556	(20,711)	229,845			20
21	Clerical & General Office Expenses	185,096	16,362	438,347	639,805		639,805	(114,303)	525,502			21
22	Employee Benefits & Payroll Taxes			1,236,826	1,236,826		1,236,826	(9,419)	1,227,407			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,405	3,405		3,405	1,052	4,457			24
25	Other Admin. Staff Transportation			2,025	2,025		2,025	950	2,975			25
26	Insurance-Prop.Liab.Malpractice			615,348	615,348		615,348	2,599	617,947			26
27	Other (specify):*							65,633	65,633			27
28	**TOTAL General Administration**	463,776	16,362	3,236,459	3,716,597	(22,106)	3,694,491	(424,735)	3,269,756			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,576,236	929,433	4,450,597	11,956,266	(22,106)	11,934,160	(369,927)	11,564,233			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.

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			209,360	209,360		209,360	66,756	276,116			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			204,402	204,402		204,402	144,998	349,400			32
33	Real Estate Taxes			581,198	581,198	22,106	603,304	7,201	610,505			33
34	Rent-Facility & Grounds			780,000	780,000		780,000	(780,000)				34
35	Rent-Equipment & Vehicles			5,996	5,996		5,996	347	6,343			35
36	Other (specify):*											36
37	TOTAL Ownership			1,780,956	1,780,956	22,106	1,803,062	(560,698)	1,242,364			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,241	1,159,254	1,311,495		1,311,495	(7,542)	1,303,953			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			480,989	480,989		480,989		480,989			42
43	Other (specify):*			129	129		129	(129)				43
44	TOTAL Special Cost Centers		152,241	1,640,372	1,792,613		1,792,613	(7,671)	1,784,942			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,576,236	1,081,674	7,871,925	15,529,835		15,529,835	(938,297)	14,591,538			45

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(24,651)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(68,153)	30		9
10	Interest and Other Investment Income	(12,529)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	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	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(322,835)	21		24
25	Fund Raising, Advertising and Promotional	(4,975)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,886)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(89,327)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (528,673)		$	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)	(409,624)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (409,624)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (938,297)		37

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

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

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

STATE OF ILLINOIS

South Suburban Rehab Center

ID# 0048678

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (537)	10	1
2	Collection Expense	(9,673)	21	2
3	Building Co. - Amortization	(25,208)	36	3
4	Capitalized R&M	(24,480)	06	4
5	PAC Dues	(20,176)	20	5
6	Marketing Expense	(129)	43	6
7	Non-Allowable Legal	(6,004)	19	7
8	Duplicate Expense	(3,120)	21	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				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**	(89,327)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

South Suburban Rehab Center

ID# 0048678

Report Period Beginning: 01/01/20

Ending: 12/31/20

	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

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			190	835								1,025	1
2	Food Purchase	(67)		138									71	2
3	Housekeeping			1,656	221								1,877	3
4	Laundry													4
5	Heat and Other Utilities	(24,651)		1,814	218								(22,619)	5
6	Maintenance	(24,480)		29,180	219								4,919	6
7	Other (specify):*			4,990	123								5,113	7
8	**TOTAL General Services**	(49,198)		37,968	1,616								(9,614)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(537)			48,513	(11,810)	(3,824)						32,342	10
10a	Therapy													10a
11	Activities													11
12	Social Services				21,910								21,910	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				10,170								10,170	15
16	**TOTAL Health Care and Programs**	(537)			80,593	(11,810)	(3,824)						64,422	16
	C. General Administration													
17	Administrative			23,718	139,535								163,253	17
18	Directors Fees													18
19	Professional Services	(6,004)		(387,094)	(120,691)								(513,789)	19
20	Fees, Subscriptions & Promotions	(25,401)		3,088	1,602								(20,711)	20
21	Clerical & General Office Expenses	(341,514)		154,340	72,871								(114,303)	21
22	Employee Benefits & Payroll Taxes			(9,419)									(9,419)	22
23	Inservice Training & Education													23
24	Travel and Seminar			504	548								1,052	24
25	Other Admin. Staff Transportation			950									950	25
26	Insurance-Prop.Liab.Malpractice			2,035	564								2,599	26
27	Other (specify):*			34,906	30,727								65,633	27
28	**TOTAL General Administration**	(372,919)		(176,972)	125,156								(424,735)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(422,654)		(139,004)	207,365	(11,810)	(3,824)						(369,927)	29

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(68,153)	131,514	3,193	202								66,756	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,529)	145,930	11,413	184								144,998	32
33	Real Estate Taxes			6,352	849								7,201	33
34	Rent-Facility & Grounds		(780,000)										(780,000)	34
35	Rent-Equipment & Vehicles			347									347	35
36	Other (specify):*	(25,208)	25,208											36
37	**TOTAL Ownership**	(105,890)	(477,348)	21,305	1,235								(560,698)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(7,542)						(7,542)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(129)											(129)	43
44	**TOTAL Special Cost Centers**	(129)					(7,542)						(7,671)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(528,673)	(477,348)	(117,699)	208,600	(11,810)	(11,366)						(938,297)	45

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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	Real Estate Taxes	516,144	Homewood Mercy Property, LLC		516,144		2
3	V	30	Depreciation		Homewood Mercy Property, LLC		131,514	131,514	3
4	V	36	Amortization		Homewood Mercy Property, LLC		25,208	25,208	4
5	V	32	Interest		Homewood Mercy Property, LLC		145,930	145,930	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,296,144			$ 818,796	$ * (477,348)	14

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

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	MAC RX	DES PLAINES	PHARMACY	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				7
8			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 190	$ 190	15
16	V	02	Food		Extended Care Consulting, LLC		138	138	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,656	1,656	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,814	1,814	18
19	V	06	Maintenance		Extended Care Consulting, LLC		3,613	3,613	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	394,478	Extended Care Consulting, LLC		7,384	(387,094)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		3,088	3,088	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		16,261	16,261	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		504	504	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		950	950	25
26	V	26	Insurance		Extended Care Consulting, LLC		2,035	2,035	26
27	V	30	Depreciation		Extended Care Consulting, LLC		3,193	3,193	27
28	V	32	Interest		Extended Care Consulting, LLC		11,413	11,413	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		6,352	6,352	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		347	347	30
31	V	06	Maintenance Salaries	1,793	Extended Care Consulting, LLC		27,360	25,567	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		4,990	4,990	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		23,718	23,718	33
34	V	21	Office and Clerical Salaries	29,603	Extended Care Consulting, LLC		167,682	138,079	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		34,906	34,906	35
36	V	22	Employee Benefits	9,419	Extended Care Consulting, LLC			(9,419)	36
37	V								37
38	V								38
39	Total			$ 435,293			$ 317,594	$ * (117,699)	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 835	$ 835	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		221	221	16
17	V	5	Utilities		Extended Care Clinical, LLC		218	218	17
18	V	6	Maintenance		Extended Care Clinical, LLC		219	219	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		123	123	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		47,289	47,289	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		1,224	1,224	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		21,910	21,910	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		10,170	10,170	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		139,535	139,535	25
26	V	19	Professional Fees	125,640	Extended Care Clinical, LLC		1,938	(123,702)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC		3,011	3,011	27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		1,602	1,602	28
29	V	21	Office Salary		Extended Care Clinical, LLC		69,539	69,539	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		3,332	3,332	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		548	548	31
32	V	26	Insurance		Extended Care Clinical, LLC		564	564	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		30,727	30,727	33
34	V	30	Depreciation		Extended Care Clinical, LLC		202	202	34
35	V	32	Interest		Extended Care Clinical, LLC		184	184	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		849	849	36
37	V								37
38	V								38
39	Total			$ 125,640			$ 334,240	$ * 208,600	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Various Equipment	15,600	Vent Lease LLC		3,790	$ (11,810)	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			$ 15,600			$ 3,790	$ * (11,810)	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 40,916	MAC Rx, LLC		$ 37,093	$ (3,824)	15
16	V	39	Ancillary	80,704	MAC Rx, LLC		73,162	(7,542)	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			$ 121,621			$ 110,255	$ * (11,366)	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group		$ 443,850	$ 443,850	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	443,850	CCS Employee Benefits Group			(443,850)	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			$ 443,850			$ 443,850	$ *	39

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Adam Vales	Relative	Clerical	0	See Attached	2.21	5.53	Alloc Salary	$ 3,945	22-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,945		13

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,219,947	38	$ 3,992	$	57,962	$ 190	1
2	02	Food	Patient Days	1,219,947	38	2,910		57,962	138	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		57,962	1,656	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		57,962	1,814	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		57,962	3,613	5
6	17	Administrative	Patient Days	1,219,947	38			57,962		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		57,962	7,384	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		57,962	3,088	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		57,962	16,261	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		57,962	504	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		57,962	950	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		57,962	2,035	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		57,962	3,193	13
14	32	Interest	Patient Days	1,219,947	38	240,208		57,962	11,413	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		57,962	6,352	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		57,962	347	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	57,962	27,360	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		57,962	4,990	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	57,962	23,718	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	57,962	167,682	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		57,962	34,906	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 317,594	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	57,962	$ 835	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		57,962	221	2
3	5	Utilities	Patient Days	603,308	20	2,264		57,962	218	3
4	6	Maintenance	Patient Days	603,308	20	2,283		57,962	219	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		57,962	123	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	57,962	47,289	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		57,962	1,224	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	57,962	21,910	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		57,962	10,170	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	57,962	139,535	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		57,962	1,938	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220			3,011	13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		57,962	1,602	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	57,962	69,539	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		57,962	3,332	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		57,962	548	17
18	26	Insurance	Patient Days	603,308	20	5,874		57,962	564	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		57,962	30,727	19
20	30	Depreciation	Patient Days	603,308	20	2,099		57,962	202	20
21	32	Interest	Patient Days	603,308	20	1,914		57,962	184	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		57,962	849	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 334,240	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	Various Equipment	Direct Allocation						3,790	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					$	$		$ 3,790	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

	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			$	$		$ 37,093	1
2	39	Ancillary	Direct Allocation						73,162	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 110,255	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 443,850	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					$	$		$ 443,850	25

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number: South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MidCap		X	Loan Payable			$	$ 1,850,000			$ 145,930	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	Line of Credit				7,328,496			204,402	6
7												7
8												8
9	TOTAL Facility Related						$	$ 9,178,496			$ 350,332	9
	B. Non-Facility Related*											
10	Interest		X								(12,529)	10
11	Alloc from Extended Care Consulting										11,413	11
12	Alloc from Extended Care Clinical										184	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (932)	14
15	TOTALS (line 9+line14)						$	$ 9,178,496			$ 349,400	15

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	570,669	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.)	$	569,087	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,582)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	589,981	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	22,106	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** $ 65,054 **For** 2017 **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.	$	610,506	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	508,556	8
	2016	512,278	9
	2017	544,941	10
	2018	543,494	11
	2019	561,886	12

2020 Accrual = $561,886 x 1.05 = $589,981 (rounded)

Allocated from Extended Care Consulting $6,352

Allocated from Extended Care Clinical $849

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 561,886.42	$ 561,886.42
2.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 6,352.40
3.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 848.77
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 956,211.80	$ 569,087.59

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2007	$ 228,875	1
2	Allocated from Care Center Building			29,950	2
3	TOTALS			$ 258,825	3

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 131,514	35	$ 128,439	$ (3,075)	$ 1,612,521	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	32,656		20	911	911	26,546	9
10	Various			2008	35,282		20	1,765	1,765	25,966	10
11	Various			2009	29,244		20	1,330	1,330	18,493	11
12	Various			2010	36,366		20	1,401	1,401	23,299	12
13	Various			2011	151,862		20	6,310	6,310	92,273	13
14	Various			2012	138,639		20	6,426	6,426	66,969	14
15	Various			2013	526,107		20	19,310	19,310	337,809	15
16	Various			2014	586,101		20	29,306	29,306	259,093	16
17	Various			2015	529,672		20	26,485	26,485	141,900	17
18	Various			2016	116,810		20	5,841	5,841	26,973	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		148,962	2,311		2,311		105,113	68
69	Financial Statement Depreciation			209,360			(209,360)		69
70	TOTAL (lines 4 thru 69)		$ 6,827,050	$ 343,185		$ 229,835	$ (113,350)	$ 2,736,955	70

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 6,827,050	$ 343,185		$ 229,835	$ (113,350)	$ 2,736,955	1
2	Kone Inc. - 2 Elevators - Additional Cost	2017	5,095		20	255	255	1,784	2
3	Mechanical Room Elevator A/C Unit	2017	5,800		20	290	290	1,112	3
4	3.5 Ton Evaporator (100 Wing)	2017	8,750		20	438	438	1,568	4
5	3.5 Ton Evaporator (500 Wing)	2017	8,950		20	448	448	1,604	5
6	10-Ton A/C Rooftop Unit	2017	11,800		20	590	590	2,114	6
7	Smoke Hut	2017	5,800		20	290	290	991	7
8	10-Ton A/C Rooftop Unit	2017	11,800		20	590	590	1,918	8
9	3 Fire Doors	2017	5,086		20	254	254	847	9
10	Exhause Fan - 1St Floor Shower Room	2017	2,975		20	149	149	471	10
11	Cubicle Curtains	2017	2,606		20	130	130	488	11
12	Installed New Mixing Valve On Hot Water System	2017	3,976		20	199	199	746	12
13	Fire System Repair	2017	2,619		20	131	131	513	13
14	Install New Water Heater And New Electrical Circuit System	2018	3,200		20	160	160	427	14
15	Replaced 5 Fire/Smoke Damper Actuators,3 Thermal Links	2018	3,340		20	167	167	501	15
16	Parking Lot Piping - Remove/Replace Catch Basin	2018	6,564		20	328	328	738	16
17	Install Mechanical Shutoff Gas Valve, Piping, Wiring	2018	3,155		20	158	158	355	17
18	Boiler Repair - Main Pump, Pump Motor	2018	2,818		20	141	141	317	18
19	800Btu Window Mounted Air Conditioner	2018	3,710		20	186	186	495	19
20	Repair Basement Floor Due To Flood	2019	26,000		20	1,300	1,300	1,733	20
21	Waterproofing, Drain Tile, Electrical, Sump Pump, Drains	2019	60,676		20	3,034	3,034	4,352	21
22	Dementia Wing Floor And Wall Repair	2019	79,762		20	3,988	3,988	5,129	22
23	Boiler Repair - Rebuild Mixing Valve	2019	3,274		20	164	164	328	23
24	Install New Aluminum Thresholds Around Exterior Doors	2019	2,606		20	130	130	260	24
25	Service Elevator - New Packing	2019	4,472		20	224	224	448	25
26	Service Elevator - Adjusted Door Operator Limit Switch	2019	3,724		20	186	186	372	26
27	Paint	2019	2,896		20	145	145	290	27
28	Generator Repair-Radiator,Water Pump,Belts,Hose,Thermostat,F	2019	23,576		20	1,179	1,179	2,358	28
29	Basement Remodel-New Tile,Ceilings,Walls,Painting	2020	165,455		20	8,273	8,273	8,273	29
30	Replacement Of Pump And Motor In Basement	2020	8,539		20	427	427	427	30
31	Roof Repairs	2020	11,800		20	590	590	590	31
32	Repair Sewage Ejector System In Basement	2020	4,403		20	220	220	220	32
33	Boiler Repairs - Replace Faulty Controls	2020	3,122		20	156	156	156	33
34	TOTAL (lines 1 thru 33)		$ 7,325,399	$ 343,185		$ 254,755	$ (88,431)	$ 2,778,880	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,325,399	$ 343,185		$ 254,755	$ (88,431)	$ 2,778,880	1
2	Circulating Pump Repair - Replace Impellar	2020	4,143		20	207	207	207	2
3	Roof Top Unit Repairs - Belt, Circuit Control	2020	2,514		20	126	126	126	3
4	Generator - Replace Control Board, Repair Engine	2020	3,587		20	179	179	179	4
5	Ats 2 - Replace Emergency Position Indicating Lamp	2020	3,921		20	196	196	196	5
6	Change Out 4" Water Flow Switch In Basement	2020	2,790		20	140	140	140	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,342,354	$ 343,185		$ 255,603	$ (87,583)	$ 2,779,727	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,342,354	$ 343,185		$ 255,603	$ (87,583)	$ 2,779,727	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,342,354	$ 343,185		$ 255,603	$ (87,583)	$ 2,779,727	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,342,354	$ 343,185		$ 255,603	$ (87,583)	$ 2,779,727	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)		$ 7,342,354	$ 343,185		$ 255,603	$ (87,583)	$ 2,779,727	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	36,408	934	35	934		17,076	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	11,403	253	35	253		3,410	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	4,864	125	35	125		2,282	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	30,075		20			30,075	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	35,443		20			35,443	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,761		20			1,761	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	318	16	20	16		191	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	3,050	153	20	153		1,067	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	501	25	20	25		324	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,979	99	20	99		495	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,433	172	20	172		687	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,573	79	20	79		236	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	593	30	20	30		59	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	158	8	20	8		8	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	4,018		20			4,018	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	4,736		20			4,736	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	235		20			235	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	42	2	20	2		25	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	395	20	20	20		138	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	67	3	20	3		43	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	264	13	20	13		66	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	459	23	20	23		92	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	210	10	20	10		32	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	79	4	20	4		8	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	21	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 142,084	$ 1,967		$ 1,967	$	$ 102,508	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 142,084	$ 1,967		$ 1,967	$	$ 102,508	1
2									2
3									3
4									4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting	2007	219	11	20	11		153	8
9	Allocated from Extended Care Consulting	2009	131	7	20	7		79	9
10	Allocated from Extended Care Consulting	2010	1,282	64	20	64		705	10
11	Allocated from Extended Care Consulting	2011	461	23	20	23		231	11
12	Allocated from Extended Care Consulting	2012	152	8	20	8		68	12
13	Allocated from Extended Care Consulting	2014	2,107	105	20	105		738	13
14	Allocated from Extended Care Consulting	2016	2,527	126	20	126		632	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)		$ 148,962	$ 2,311		$ 2,311	$	$ 105,113	34

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 205,142	$ 1,083	$ 20,513	$ 19,430	10	$ 118,943	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,754,873				10	1,754,873	73
74								74
75	TOTALS	$ 1,960,015	$ 1,083	$ 20,513	$ 19,430		$ 1,873,816	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	$ 4,936	$	$	$	5	$ 4,936	76
77		Alloc. Extended Care Consulting	2014	1,210				5	1,210	77
78										78
79										79
80	TOTALS			$ 6,146	$	$	$		$ 6,146	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)	$ 9,567,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 344,268	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 276,116	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (68,153)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,659,690	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

16. Rental Amount for movable equipment: $ 6,343 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 453,710	$		$ 453,710	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			224,930			224,930	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			455,765			455,765	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				97,874		97,874	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					24,849	54,367		79,216	13
14	TOTAL			$		$ 1,159,254	$ 152,241		$ 1,311,495	14

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

STATE OF ILLINOIS

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 534,195	$ 534,195	1
2	Cash-Patient Deposits	125,649	125,649	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,127,022	2,127,022	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	272,700	272,700	6
7	Other Prepaid Expenses	274,622	274,622	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	1,955	1,955	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,336,143	$ 3,336,143	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	2,298,588	2,298,588	15
16	Equipment, at Historical Cost	449,232	2,521,232	16
17	Accumulated Depreciation (book methods)	(1,876,334)	(6,236,084)	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	447,666	336,962	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,319,152	$ 2,863,589	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,655,295	$ 6,199,732	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 758,277	$ 758,277	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	126,329	126,329	28
29	Short-Term Notes Payable	7,328,496	7,328,496	29
30	Accrued Salaries Payable	489,677	489,677	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,313	27,313	31
32	Accrued Real Estate Taxes(Sch.IX-B)	589,981	589,981	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,728,025	2,728,025	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,048,098	$ 12,048,098	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,850,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	3,135,773	7,470,840	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,135,773	$ 9,320,840	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,183,871	$ 21,368,938	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (10,528,576)	$ (15,169,206)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,655,295	$ 6,199,732	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (12,830,507)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (12,830,508)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,301,932	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)**	$ 2,301,932	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)**	$ (10,528,576)	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	$ 13,325,695	1
2	Discounts and Allowances for all Levels	(2,272,834)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,052,861	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,806,200	6
7	Oxygen	628	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,806,828	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	108,694	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,559	19
20	Radiology and X-Ray	4,090	20
21	Other Medical Services	3,214	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 161,557	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,529	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,529	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	3,797,992	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,797,992	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,831,767	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,879,037	31
32	Health Care	6,360,632	32
33	General Administration	3,716,597	33
	B. Capital Expense		
34	Ownership	1,780,956	34
	C. Ancillary Expense		
35	Special Cost Centers	1,311,624	35
36	Provider Participation Fee	480,989	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,529,835	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,301,932	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,301,932	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,381,934	44
45	Private Pay - Net Inpatient Revenue	239,035	45
46	Medicare - Net Inpatient Revenue	402,674	46
47	Other-(specify) Hospice	921,816	47
48	Other-(specify) Insurance	107,402	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,052,861	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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,928	2,244	$ 141,600	$ 63.10	1
2	Assistant Director of Nursing	1,713	1,863	76,128	40.86	2
3	Registered Nurses	22,737	24,193	984,712	40.70	3
4	Licensed Practical Nurses	50,690	53,329	1,864,400	34.96	4
5	CNAs & Orderlies	77,839	81,479	1,448,885	17.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,551	13,230	241,454	18.25	8
9	Activity Director	4,126	4,739	86,038	18.16	9
10	Activity Assistants	9,812	10,327	134,537	13.03	10
11	Social Service Workers	6,662	7,187	186,305	25.92	11
12	Dietician					12
13	Food Service Supervisor	2,674	2,886	76,278	26.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,311	23,986	314,774	13.12	15
16	Dishwashers					16
17	Maintenance Workers	6,886	7,354	130,628	17.76	17
18	Housekeepers	19,701	21,462	291,670	13.59	18
19	Laundry	1,776	1,828	22,235	12.16	19
20	Administrator	2,092	2,187	159,658	73.01	20
21	Assistant Administrator	2,030	2,191	119,022	54.32	21
22	Other Administrative					22
23	Office Manager	2,245	2,459	57,458	23.37	23
24	Clerical	6,469	7,355	127,638	17.35	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	1,976	2,082	33,554	16.12	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	4,816	5,058	79,262	15.67	33
34	TOTAL (lines 1 - 33)	261,034	277,440	$ 6,576,236 *	$ 23.70	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	861	$ 47,921	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,578	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Per Visit	498	10a-03	41
42	Respiratory Therapy Consultant	Per Visit	6,536	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Per Case	594	11-03	44
45	Social Service Consultant	Per Case	1,155	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	10,500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	861	$ 114,782		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	271	$ 33,300	10-03	50
51	Licensed Practical Nurses	1,495	113,633	10-03	51
52	Certified Nurse Assistants/Aides	9,657	487,054	10-03	52
53	TOTAL (lines 50 - 52)	11,423	$ 633,987		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Boshes	Administrator	0	$ 159,658
Bonzetta Williams	Assistant Admin	0	119,022
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 278,680

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 25,950
ECC Clinical	Home Office Expense	125,640
ECC Consulting	Home Office Expense	394,478
Personnel Planners, Inc.	Unemployment Tax Consultant	2,211
National Datacare Corporation	Resident Refund Processing	3,027
Paycor	Payroll Processing	30,352
Ability Network	Medicare Billing Services	32,218
Skidelsky & Associates	R/E Tax Assessment	22,085
Pinnacle Quality	Customer Satisfaction	870
Red Eyed Moose	Software Support	5,284
See Attached	Legal	25,884
See Supplemental Schedule		21,954
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 689,953

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 256,737
Unemployment Compensation Insurance	71,751
FICA Taxes	503,082
Employee Health Insurance	355,219
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	9,433
Other Employee Welfare	30,775
Holiday Expense	410
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,227,407

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	179,862
Health Care Worker Background Check	
(Indicate # of checks performed 225)	2,250
Patient Background Checks 367	366
Dues & Subscriptions	27,192
Licenses & Fees	13,495
See Supplemental Schedule	4,690
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 229,845

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,405
See Supplemental Schedule	1,052
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,457

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $40,352**

(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. $ **65,131** 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. $ **480,989**
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? **N/A** Indicate the amount. $ ______

(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? **N/A**
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