

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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.

**I. IDPH License ID Number:** 0048678

**Facility Name:** South Suburban Rehab Center

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

**County:** Cook

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

**HFS ID Number:** 205897291001

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____
	(Type or Print Name) _____ (Date) _____
<b>Paid Preparer</b>	(Title) _____
	(Signed) _____ (Date) _____
<b>Paid Preparer</b>	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	94,535	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,535	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,883	2,883	8
9	SNF/PED					9
10	ICF	27,256	1,375	27	28,658	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,256	1,375	2,910	31,541	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 33.36%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 01/01/07

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 04/01/7 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 259 and days of care provided 2,883

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	132,594	14,057	7,327	153,978		153,978	1,988	155,966		1
2	Food Purchase		103,013		103,013		103,013	118	103,131		2
3	Housekeeping	125,185	18,721		143,906		143,906	(364)	143,542		3
4	Laundry	59,972	6,104		66,076		66,076	(83)	65,993		4
5	Heat and Other Utilities			223,720	223,720		223,720	1,260	224,980		5
6	Maintenance	123,812		146,255	270,067		270,067	40,080	310,147		6
7	Other (specify):*							5,784	5,784		7
8	<b>TOTAL General Services</b>	<b>441,563</b>	<b>141,895</b>	<b>377,302</b>	<b>960,760</b>		<b>960,760</b>	<b>48,783</b>	<b>1,009,543</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,500	14,500		14,500		14,500		9
10	Nursing and Medical Records	1,151,594	54,014	5,427	1,211,035		1,211,035	11,211	1,222,246		10
10a	Therapy	69,263		2,424	71,687		71,687	1,409	73,096		10a
11	Activities	104,545	6,739	2,184	113,468		113,468		113,468		11
12	Social Services	93,563		1,478	95,041		95,041	4,074	99,115		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,776	2,776		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,418,965</b>	<b>60,753</b>	<b>26,013</b>	<b>1,505,731</b>		<b>1,505,731</b>	<b>19,470</b>	<b>1,525,201</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	82,762			82,762		82,762	31,350	114,112		17
18	Directors Fees										18
19	Professional Services			278,537	278,537		278,537	(185,810)	92,727		19
20	Dues, Fees, Subscriptions & Promotions			43,615	43,615		43,615	(1,230)	42,385		20
21	Clerical & General Office Expenses	113,425	17,993	94,579	225,997		225,997	17,470	243,467		21
22	Employee Benefits & Payroll Taxes			592,855	592,855		592,855	(1,579)	591,276		22
23	Inservice Training & Education										23
24	Travel and Seminar			698	698		698	885	1,583		24
25	Other Admin. Staff Transportation			2,852	2,852		2,852	753	3,605		25
26	Insurance-Prop.Liab.Malpractice			255,558	255,558		255,558	775	256,333		26
27	Other (specify):*							17,056	17,056		27
28	<b>TOTAL General Administration</b>	<b>196,187</b>	<b>17,993</b>	<b>1,268,694</b>	<b>1,482,874</b>		<b>1,482,874</b>	<b>(120,330)</b>	<b>1,362,544</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,056,715</b>	<b>220,641</b>	<b>1,672,009</b>	<b>3,949,365</b>		<b>3,949,365</b>	<b>(52,077)</b>	<b>3,897,288</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehab Center #0048678 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			1,307	1,307		1,307	325,468	326,775		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			255,368	255,368		255,368	605,700	861,068		32
33	Real Estate Taxes			450,000	450,000		450,000	1,213,064	1,663,064		33
34	Rent-Facility & Grounds			1,084,249	1,084,249		1,084,249	(1,082,463)	1,786		34
35	Rent-Equipment & Vehicles			3,881	3,881		3,881	206	4,087		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,794,805	1,794,805		1,794,805	1,061,975	2,856,780		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		4,787	5,309	10,096		10,096	(140)	9,956		39
40	Barber and Beauty Shops			953	953		953		953		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			141,803	141,803		141,803		141,803		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		4,787	148,065	152,852		152,852	(140)	152,712		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,056,715	225,428	3,614,879	5,897,022		5,897,022	1,009,758	6,906,780		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	69,352	30		9
10	Interest and Other Investment Income	(1,295)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	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	(595)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,239)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(238,040)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (203,862)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,213,620		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,213,620		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 1,009,758		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	Miscellaneous Income	\$ (40,360)	21	1
2	Patent Clothing	(51)	10	2
3	Theft Loss	(394)	21	3
4	Collection Expense	(182)	21	4
5	Annual Report	(150)	20	5
6	COPI Dues	(1,278)	20	6
7	Capitalized R&M	(2,500)	06	7
8	Non-Allowable Legal Fees	(193,125)	19	8
9				9
10				10
11				11
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98				98
99				99
100				100
101	Total	(238,040)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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)	
	<b>A. General Services</b>													
1	Dietary			132	1,877	36		(57)					1,988	1
2	Food Purchase	(45)		163									118	2
3	Housekeeping			248	25			(637)					(364)	3
4	Laundry							(83)					(83)	4
5	Heat and Other Utilities			1,185	64	11							1,260	5
6	Maintenance	(2,500)		42,568	8	4							40,080	6
7	Other (specify):*			5,606	178								5,784	7
8	<b>TOTAL General Services</b>	<b>(2,545)</b>		<b>49,902</b>	<b>2,152</b>	<b>51</b>		<b>(777)</b>					<b>48,783</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(51)			14,636			(3,374)					11,211	10
10a	Therapy				1,409								1,409	10a
11	Activities													11
12	Social Services				4,074								4,074	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,776								2,776	15
16	<b>TOTAL Health Care and Programs</b>	<b>(51)</b>			<b>22,895</b>			<b>(3,374)</b>					<b>19,470</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			5,654	25,606	90							31,350	17
18	Directors Fees													18
19	Professional Services	(193,125)		6,246	1,068	1							(185,810)	19
20	Fees, Subscriptions & Promotions	(4,667)		3,414	16	7							(1,230)	20
21	Clerical & General Office Expenses	(71,531)		83,744	6,628	150	(1,521)						17,470	21
22	Employee Benefits & Payroll Taxes			(1,100)	(308)			(171)					(1,579)	22
23	Inservice Training & Education													23
24	Travel and Seminar			578	307								885	24
25	Other Admin. Staff Transportation			748		5							753	25
26	Insurance-Prop.Liab.Malpractice			757	8	10							775	26
27	Other (specify):*			12,667	4,353	36							17,056	27
28	<b>TOTAL General Administration</b>	<b>(269,323)</b>		<b>112,708</b>	<b>37,678</b>	<b>299</b>	<b>(1,521)</b>	<b>(171)</b>					<b>(120,330)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(271,919)</b>		<b>162,610</b>	<b>62,725</b>	<b>350</b>	<b>(1,521)</b>	<b>(4,322)</b>					<b>(52,077)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	69,352	245,661	9,659	406	8	382						325,468	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,295)	586,485	18,225	1,747	13	525						605,700	32
33	Real Estate Taxes		1,211,554	1,414	95	1							1,213,064	33
34	Rent-Facility & Grounds		(1,084,000)	1,527		10							(1,082,463)	34
35	Rent-Equipment & Vehicles			201	3	2							206	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>68,057</b>	<b>959,700</b>	<b>31,026</b>	<b>2,251</b>	<b>34</b>	<b>907</b>						<b>1,061,975</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(140)					(140)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>							(140)					(140)	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(203,862)	959,700	193,636	64,976	384	(614)	(4,462)					1,009,758	45

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning:

01/01/07

Ending:

12/31/07

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Homewood Mercy Property, LLC		Building Co.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,084,000	Homewood Mercy Property, LLC	100.00%	\$	\$ (1,084,000)	1
2	V	32 Interest				586,485	586,485	2
3	V	33 Real Estate Taxes				1,211,554	1,211,554	3
4	V	30 Depreciation Expense				245,661	245,661	4
5	V							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		\$ 1,084,000			\$ 2,043,700	\$ * 959,700	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center# 0048678Report Period Beginning: 01/01/07Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 132	\$ 132	15
16	V	02	Food		Care Centers, Inc.	100.00%	163	163	16
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	248	248	17
18	V	05	Utilities		Care Centers, Inc.	100.00%	1,185	1,185	18
19	V	06	Maintenance		Care Centers, Inc.	100.00%	1,954	1,954	19
20	V	17	Administrative		Care Centers, Inc.	100.00%	1,184	1,184	20
21	V	19	Professional Fees		Care Centers, Inc.	100.00%	6,246	6,246	21
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	3,414	3,414	22
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	9,895	9,895	23
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	578	578	24
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	748	748	25
26	V	26	Insurance		Care Centers, Inc.	100.00%	757	757	26
27	V	30	Depreciation		Care Centers, Inc.	100.00%	9,659	9,659	27
28	V	32	Interest		Care Centers, Inc.	100.00%	18,225	18,225	28
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,414	1,414	29
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	1,527	1,527	30
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	201	201	31
32	V	06	Maintenance	1,348	Care Centers, Inc.	100.00%	41,962	40,614	32
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	5,606	5,606	33
34	V	17	Administrative		Care Centers, Inc.	100.00%	4,470	4,470	34
35	V	21	Office and Clerical	5,986	Care Centers, Inc.	100.00%	79,835	73,849	35
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	12,667	12,667	36
37	V	22	Employee Benefits	1,100	Care Centers, Inc.	100.00%		(1,100)	37
38	V								38
39	Total		\$ 8,434				\$ 202,070	\$ * 193,636	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center # 0048678 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 25	\$ 25	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	64	64	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	8	8	17	
18	V	19	Professional Fees		Care Centers Clinical, Inc.	100.00%	1,068	1,068	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	16	16	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	62	62	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	307	307	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	8	8	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	406	406	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	1,747	1,747	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	95	95	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	3	3	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	1,877	1,877	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	178	178	28	
29	V	10	Nursing Salary	1,765	Care Centers Clinical, Inc.	100.00%	16,401	14,636	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,409	1,409	30	
31	V	12	Social Service Salary	288	Care Centers Clinical, Inc.	100.00%	4,362	4,074	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	2,776	2,776	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	25,606	25,606	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	6,566	6,566	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	4,353	4,353	35	
36	V	22	Employee Benefits	308	Care Centers Clinical, Inc.	100.00%		(308)	36	
37	V								37	
38	V								38	
39	Total			\$ 2,361			\$ 67,337	\$ * 64,976	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center# 0048678Report Period Beginning: 01/01/07Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 54	54	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%	-		16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	11	11	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	4	4	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	1	1	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	7	7	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	23	23	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	5	5	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	10	10	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	8	8	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	13	13	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	1	1	26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	10	10	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	2	2	28
29	V	01 Dietary	26	Care Centers Health Systems, Inc.	100.00%	8	(18)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary		Care Centers Health Systems, Inc.	100.00%			35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	90	90	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	127	127	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	36	36	38
39	Total		\$ 26			\$ 410	\$ *	384 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$	\$	15	
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16	
17	V	30	Depreciation		Vent Lease, LLC.	100.00%			17	
18	V	32	Interest		Vent Lease, LLC.	100.00%			18	
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	382	382	19	
20	V	32	Interest		Vent Lease, LLC.	100.00%	525	525	20	
21	V	21	Office and Clerical	1,521	Vent Lease, LLC.	100.00%		(1,521)	21	
22	V	39	Ancillary		Vent Lease, LLC.	100.00%			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		\$ 1,521				\$ 907	\$ *	(614)	39

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

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	1 Dietary	\$ 707	Xcel Supply, LLC	100.00%	\$ 650	\$ (57)	15
16	V	3 Housekeeping	7,891	Xcel Supply, LLC	100.00%	7,254	(637)	16
17	V	4 Laundry	1,026	Xcel Supply, LLC	100.00%	943	(83)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	41,844	Xcel Supply, LLC	100.00%	38,470	(3,374)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	2,121	Xcel Supply, LLC	100.00%	1,950	(171)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	1,737	Xcel Supply, LLC	100.00%	1,597	(140)	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		\$ 55,326			\$ 50,864	\$ * (4,462)	39

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

**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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 13,920	\$ 13,920	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	13,920	CCS Employee Benefits Group	100.00%		(13,920)	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			\$ 13,920			\$ 13,920	\$ *	39

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

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/07 Ending: 12/31/07

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	99.00%	See Attached	0.65	1.40%		\$	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.07	1.94%	Alloc. Salary	2,622	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.09	0.22%	Alloc. Salary	120	21-7	3
4	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.08	0.22%	Alloc. Salary	66	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,808		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Care Centers, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 31,541	\$ 132	1
2	2	Food	Patient Days	1,625,640	33	8,403	31,541	163	2
3	3	Housekeeping	Patient Days	1,625,640	33	12,807	31,541	248	3
4	5	Utilities	Patient Days	1,625,640	33	61,054	31,541	1,185	4
5	6	Maintenance	Patient Days	1,625,640	33	100,693	31,541	1,954	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	31,541	1,184	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	31,541	6,246	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	31,541	3,414	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	31,541	9,895	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	31,541	578	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	31,541	748	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	31,541	757	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	31,541	9,659	13
14	32	Interest	Patient Days	1,625,640	33	939,326	31,541	18,225	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	31,541	1,414	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	31,541	1,527	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	31,541	201	17
18	6	Maintenance	Patient Days	1,625,640	33	187,019	187,019	3,629	18
19	6	Maintenance	Direct Allocation			456,812	456,812	38,333	19
20	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	31,541	5,606	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	4,470	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	73,331	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	6,504	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	31,541	12,667	24
25	TOTALS					\$ 8,891,187	\$ 5,143,113	\$ 202,070	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center# 0048678 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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

Name of Related Organization Care Center Clinical, Inc.  
 Street Address 2201 West 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	3	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 31,541	\$ 25	1	
2	5	Utilities	Patient Days	1,625,640	32	3,307	31,541	64	2	
3	6	Maintenance	Patient Days	1,625,640	32	410	31,541	8	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	31,541	1,068	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	31,541	16	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	31,541	62	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	31,541	307	7	
8	26	Insurance	Patient Days	1,625,640	32	409	31,541	8	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	31,541	406	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	31,541	1,747	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	31,541	95	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	31,541	3	12	
13	1	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	31,541	1,877	13
14	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	31,541	178	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	31,541	14,577	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	31,541	1,409	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	31,541	4,046	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	31,541	2,583	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	31,541	25,606	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	31,541	6,566	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	31,541	4,353	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		1,824	22
23	12	Social Service Salary	Direct Allocation			8,845	8,845		316	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			193	24
25	TOTALS					\$ 3,374,560	\$ 2,809,548	\$ 67,337	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Care Centers Health Systems, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Gross Billable Income	4,431,674	33	94,358	2,559	54	1
2	3	Housekeeping	Gross Billable Income	4,431,674	33	663	2,559		2
3	5	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	2,559	11	3
4	6	Maintenance	Gross Billable Income	4,431,674	33	7,696	2,559	4	4
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	2,559	1	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	2,559	7	6
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	2,559	23	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	2,559	5	8
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	2,559	10	9
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	2,559	8	10
11	32	Insurance	Gross Billable Income	4,431,674	33	22,225	2,559	13	11
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	2,559	1	12
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	2,559	10	13
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	2,559	2	14
15	1	Dietary	Direct Billable Income	341,879	33	112,243	26	8	15
16	2	Food	Direct Billable Income	25	33	8			16
17	3	Housekeeping	Direct Billable Income	29	33	10			17
18	10	Nursing	Direct Billable Income	69,616	33	22,856			18
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298			21
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	2,559	90
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	2,559	127
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	2,559	36	24
25	TOTALS					\$ 2,152,813	\$ 374,301	\$ 410	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Repairs	Direct Billing	892,186	27	\$ 35,557			1
2	21	Office and Clerical	Direct Billing	892,186	27	44			2
3	30	Depreciation	Direct Billing	892,186	27	280,000			3
4	32	Interest	Direct Billing	892,186	27	23,404			4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	31,541	382	5
6	32	Interest	Patient Days	1,625,640	33	27,081	31,541	525	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					\$ 385,763	\$	907	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Xcel Supply, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$ 650	1
2	3	Housekeeping	Direct Allocation					7,254	2
3	4	Laundry	Direct Allocation					943	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					38,470	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					1,950	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					1,597	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				\$	\$		\$ 50,864	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678 Report Period Beginning: 01/01/07

Ending: 12/31/07

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 13,920	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				\$	\$		\$ 13,920	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

# 0048678 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LaSalle Bank		X	Mortgage			\$	\$ 6,178,107		\$ 586,485	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
<b>Working Capital</b>																				
6	Lake Forest Bank		X							20,713	6									
7	LaSalle Bank		X							159,949	7									
8	See Supplemental Schedule									74,706	8									
9	<b>TOTAL Facility Related</b>						\$	\$ 6,178,107		\$ 841,853	9									
<b>B. Non-Facility Related*</b>																				
10	Allocate Care Centers, Inc.	X								18,225	10									
11	Allocate CC Clinical, Inc.	X								1,747	11									
12	Allocate CC Health Sys.	X								13	12									
13	See Supplemental Schedule									(770)	13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 19,215	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 6,178,107		\$ 861,068	15									

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

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

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

Facility Name & ID Number

South Suburban Rehab Center

# 0048678

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

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

	1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
<b>Working Capital</b>																				
8	Cole Taylor Bank		X				\$	\$			\$	24,389	8							
9	Bank Leumi		X									50,317	9							
10													10							
11													11							
12													12							
13													13							
14	<b>TOTAL Working Capital</b>											14								
<b>B. Non-Facility Related*</b>																				
15	Allocate Vent Lease LLC	X					\$	\$			\$	525	15							
16	Interest Income		X									(1,295)	16							
17													17							
18													18							
19													19							
20	<b>TOTAL Non-Facility Related</b>											20								

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>32-05-400-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>445,014.81</u>	\$ <u>445,014.81</u>
2. <u>See Attached</u>	<u>Care Centers, Inc. Allocation</u>	\$ <u>46,662.50</u>	\$ <u>905.36</u>
3. <u>See Attached</u>	<u>Care Centers Clinical Allocation</u>	\$ <u>4,834.42</u>	\$ <u>93.80</u>
4. <u>See Attached</u>	<u>Care Centers Health Sys Alloc.</u>	\$ <u>2,476.87</u>	\$ <u>1.43</u>
5. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>24,152.48</u>	\$ <u>468.61</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>523,141.08</u>	\$ <u>446,484.01</u>

**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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME South Suburban Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number South Suburban Rehab Center

# 0048678 Report Period Beginning:

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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  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	\$ 600,000	1
2	Allocate Care Centers, Inc.			7,758	2
3	TOTALS			\$ 607,758	3

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**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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

\*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center

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**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		3,196,000	245,661		91,314	(154,347)	91,314	67
68		43,586	2,293		2,293		14,380	68
69			1,307			(1,307)		69
70		\$ 3,239,586	\$ 249,261		\$ 93,607	\$ (155,654)	\$ 105,694	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,239,586	\$ 249,261		\$ 93,607	\$ (155,654)	\$ 105,694	1
2	Replace Walk-In Cooler Doors	2007	4,750		20	339	339	339	2
3	Remove 15 Doors	2007	10,000		20	208	208	208	3
4	Smoke Detector	2007	9,691		20	461	461	461	4
5	Preventer, 8000-F Strainer & Acces.	2007	5,365		20	45	45	45	5
6	Painting (Transfer Expense From Home Office)	2007	19,621		20	14,716	14,716	14,716	6
7	Painting (Transfer Expense From Home Office)	2007	22,946		20	1,912	1,912	1,912	7
8	Roof Repair	2007	2,500		20	125	125	125	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
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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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
19									19
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21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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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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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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# 0048678

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12E, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
18									18
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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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	<b>Totals from Page 12F, Carried Forward</b>		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12G, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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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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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12J, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12K, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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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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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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 12L, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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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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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12M, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12N, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	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)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12O, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12P, Carried Forward		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,314,459	\$ 249,261		\$ 111,413	\$ (137,848)	\$ 123,500	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF 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	\$ 3,196,000	\$	35	\$ 91,314	\$ 91,314	\$ 91,314	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	<b>Current Book Depreciation</b>					245,661			(245,661)		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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>3,196,000</b>	\$	<b>245,661</b>	\$	<b>91,314</b>	\$	<b>(154,347)</b>	\$	<b>91,314</b>	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	Allocate Care Centers, Inc. 2201 Main LLC		2002	2002	\$ 8,640	\$ 222	39	\$ 222	\$	\$ 1,172	4
5	Allocate Care Centers, Inc. - CCI Building			1996	14,650	376	39	376		4,148	5
6	Allocate Care Centers Clinical, Inc.		2002	2002	895	23	39	23		121	6
7	Allocate Care Centers Health Systems, Inc.		2002	2002	14		39			2	7
8											8
	Improvement Type**										
9	Allocate Care Centers, Inc. 2201 Main LLC			2002	7,137	652	20	652		3,268	9
10	Allocate Care Centers, Inc. 2201 Main LLC			2003	8,411	769	20	769		3,851	10
11	Allocate Care Centers, Inc. 2201 Main LLC			2005	418	44	20	44		106	11
12											12
13	Allocate Care Centers, Inc.			2007	89	6	20	6		6	13
14											14
15	Allocate Care Centers, Inc. - CCI Building			1996	247	-	20	-		247	15
16	Allocate Care Centers, Inc. - CCI Building			1997	1,407	46	20	46		699	16
17											17
18	Allocate Care Centers Clinical, Inc.			2002	739	68	20	68		339	18
19	Allocate Care Centers Clinical, Inc.			2003	871	80	20	80		399	19
20	Allocate Care Centers Clinical, Inc.			2005	43	5	20	5		11	20
21											21
22	Allocate Care Centers Health Systems, Inc.			2002	11	1	20	1		5	22
23	Allocate Care Centers Health Systems, Inc.			2003	13	1	20	1		6	23
24	Allocate Care Centers Health Systems, Inc.			2005	1	-	20	-		-	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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								67		
68								68		
69								69		
70	<b>TOTAL (lines 4 thru 69)</b>	\$	43,586	\$	2,293	\$	2,293	\$	14,380	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 57,234	\$ 6,943	\$ 6,943	\$	10	\$ 52,467	71
72	Current Year Purchases	2,072,489	68	207,268	207,200	10	207,268	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,129,723	\$ 7,011	\$ 214,211	\$ 207,200		\$ 259,735	75

D. Vehicle Depreciation (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		Allocate Care Centers, Inc.	2007	\$ 16,300	\$ 946	\$ 946	\$	5	\$ 13,389	76
77		Allocate Care Centers Clinical, In	2007	1,395	206	206		5	264	77
78		Allocate Care Centers Health Sys.	2007	7				5		78
79										79
80	TOTALS			\$ 17,702	\$ 1,152	\$ 1,152	\$		\$ 13,653	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)	\$ 6,069,642	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 257,424	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 326,776	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 69,352	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 396,888	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Storage Rental				249			5
6	Allocate Care Centers, Inc.				1,537			6
7	TOTAL				\$ 1,786			7

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \_\_\_\_\_ \*

**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: \$ 4,087 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 1,812	\$		\$ 1,812	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			2,946			2,946	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 prescripts				3,050		3,050	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					551	1,737		2,288	13
14	TOTAL			\$		\$ 5,309	\$ 4,787		\$ 10,096	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center# 0048678Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 500	\$ (3,165)	1
2	Cash-Patient Deposits	13,598	13,598	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	438,648	438,648	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	483	483	6
7	Other Prepaid Expenses	530	530	7
8	Accounts Receivable (owners or related parties)	(128,425)	56,453	8
9	Other(specify): <u>See Attached Schedule</u>	2,423	2,423	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 327,757	\$ 508,970	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		3,196,000	14
15	Leasehold Improvements, at Historical Cost	25,056	25,056	15
16	Equipment, at Historical Cost	4,750	2,076,750	16
17	Accumulated Depreciation (book methods)	(1,307)	(2,571,601)	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): <u>See Attached Schedule</u>		1,393,365	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 28,499	\$ 4,719,570	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 356,256	\$ 5,228,540	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 335,711	\$ 335,710	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,305	13,305	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,347	198,347	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,954	7,954	31
32	Accrued Real Estate Taxes(Sch.IX-B)	450,000	1,052,180	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	718,776	3,661,063	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,724,093	\$ 5,268,559	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,178,107	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,178,107	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,724,093	\$ 11,446,666	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,367,837)	\$ (6,218,126)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 356,256	\$ 5,228,540	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (74,242)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (74,242)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(4,972,727)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,679,132	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (1,293,595)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (1,367,837)</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehab Center# 0048678Report Period Beginning: 01/01/07Ending: 12/31/07**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 882,640	1
2	Discounts and Allowances for all Levels	(1,597)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 881,043</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	8
<b>C. Other Operating Revenue</b>			
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	1,011	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	586	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,597</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,295	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,295</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	40,360	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 40,360</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 924,295</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	960,760	31
32	Health Care	1,505,731	32
33	General Administration	1,482,874	33
<b>B. Capital Expense</b>			
34	Ownership	1,794,805	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	11,049	35
36	Provider Participation Fee	141,803	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,897,022</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(4,972,727)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (4,972,727)</b>	43

\* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Suburban Rehab Center

# 0048678

Report Period Beginning: 01/01/07

Ending:

12/31/07

**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	1,863	2,640	\$ 90,793	\$ 34.39	1
2	Assistant Director of Nursing	287	303	7,463	24.63	2
3	Registered Nurses	3,580	3,849	108,031	28.07	3
4	Licensed Practical Nurses	17,756	18,842	436,756	23.18	4
5	CNAs & Orderlies	45,126	48,130	490,747	10.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,944	4,503	69,263	15.38	8
9	Activity Director	1,745	1,931	27,258	14.12	9
10	Activity Assistants	8,349	8,977	77,287	8.61	10
11	Social Service Workers	4,153	4,658	93,563	20.09	11
12	Dietician					12
13	Food Service Supervisor	1,684	1,827	29,419	16.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	157	176	3,658	20.78	15
16	Dishwashers	8,801	9,163	99,517	10.86	16
17	Maintenance Workers	7,547	8,000	123,812	15.48	17
18	Housekeepers	10,239	10,933	125,185	11.45	18
19	Laundry	5,293	5,741	59,972	10.45	19
20	Administrator	1,738	1,993	82,762	41.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,562	8,244	113,425	13.76	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	1,537	1,622	17,804	10.98	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	131,361	141,532	\$ 2,056,715 *	\$ 14.53	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	171	\$ 7,327	01-03	35
36	Medical Director	Monthly	14,500	09-03	36
37	Medical Records Consultant	25	1,142	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,520	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,184	11-03	44
45	Social Service Consultant	25	1,050	12-03	45
46	Other(specify) <u>Therapy Consult.</u>	50	2,424	10a-03	46
47	<u>Psychosocial Consultant</u>	3	140	10-03	47
48	<u>See Attached Care Centers Alloc.</u>	46	2,053	10-03	48
49	TOTAL (lines 35 - 48)	364	\$ 33,340		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number South Suburban Rehab Center

Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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. IL Council \$16,835
- (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. \$ 8,812 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. \$ 141,803  
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT