

Facility Name & ID Number South Suburban Rehabilitation Center

0048678 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	<u>259</u>	Skilled (SNF)	<u>259</u>	<u>94,794</u>	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	<u>259</u>	TOTALS	<u>259</u>	<u>94,794</u>	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				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	<u>27,192</u>	<u>2,886</u>		<u>30,078</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,192</u>	<u>2,886</u>		<u>30,078</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 31.73%

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

12 (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 04/01/07 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/08 Ending: 12/31/08

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
	A. General Services										
1	Dietary	220,036	33,991	6,167	260,194		260,194	3,055	263,249		1
2	Food Purchase		181,757		181,757		181,757	92	181,849		2
3	Housekeeping	171,159	27,879		199,038		199,038	(1,924)	197,114		3
4	Laundry	85,402	10,990		96,392		96,392	(23)	96,369		4
5	Heat and Other Utilities			220,116	220,116		220,116	1,717	221,833		5
6	Maintenance	127,518		113,524	241,042		241,042	5,674	246,716		6
7	Other (specify):*							1,701	1,701		7
8	TOTAL General Services	604,115	254,617	339,807	1,198,539		1,198,539	10,292	1,208,831		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,778,598	130,230	29,578	1,938,406		1,938,406	6,442	1,944,848		10
10a	Therapy	125,229		50	125,279		125,279	1,364	126,643		10a
11	Activities	108,614	5,876	200	114,690		114,690		114,690		11
12	Social Services	83,287		2,337	85,624		85,624	7,817	93,441		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,846	5,846		15
16	TOTAL Health Care and Programs	2,095,728	136,106	38,165	2,269,999		2,269,999	21,469	2,291,468		16
	C. General Administration										
17	Administrative	101,141			101,141		101,141	30,526	131,667		17
18	Directors Fees										18
19	Professional Services			129,633	129,633	(50,461)	79,172	(24,513)	54,659		19
20	Dues, Fees, Subscriptions & Promotions			32,058	32,058		32,058	(4,003)	28,055		20
21	Clerical & General Office Expenses	82,342	27,151	359,746	469,239		469,239	(194,364)	274,875		21
22	Employee Benefits & Payroll Taxes			505,858	505,858		505,858	(9,370)	496,488		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,200	1,200		1,200	961	2,161		24
25	Other Admin. Staff Transportation			6,382	6,382		6,382	843	7,225		25
26	Insurance-Prop.Liab.Malpractice			187,830	187,830		187,830	697	188,527		26
27	Other (specify):*							17,179	17,179		27
28	TOTAL General Administration	183,483	27,151	1,222,707	1,433,341	(50,461)	1,382,880	(182,044)	1,200,836		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,883,326	417,874	1,600,679	4,901,879	(50,461)	4,851,418	(150,284)	4,701,135		29

*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 Rehabilitation Center #0048678 Report Period Beginning: 01/01/08 Ending: 12/31/08

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
	D. Ownership										
30	Depreciation			31,859	31,859		31,859	304,177	336,036		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			192,999	192,999		192,999	283,082	476,081		32
33	Real Estate Taxes			450,000	450,000	50,461	500,461	242,030	742,491		33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(657,761)	2,239		34
35	Rent-Equipment & Vehicles			3,305	3,305		3,305	627	3,932		35
36	Other (specify):*							166,700	166,700		36
37	TOTAL Ownership			1,338,163	1,338,163	50,461	1,388,624	338,855	1,727,479		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		31,184	12,975	44,159		44,159	(9,351)	34,808		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			142,191	142,191		142,191		142,191		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		31,184	155,166	186,350		186,350	(9,351)	176,999		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,883,326	449,058	3,094,008	6,426,392		6,426,392	179,220	6,605,612		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 Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	47,555	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(174)	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	(51)	21		18
19	Entertainment				19
20	Contributions	(471)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(279,935)	21		24
25	Fund Raising, Advertising and Promotional	(6,445)	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	(31,336)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (270,858)		\$	30

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)	450,078		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 450,078		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 179,220		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

South Suburban Rehabilitation Center

ID# 0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (898)	21	1
2	Jury Duty	(34)	10	2
3	Patient Clothing	(59)	10	3
4	Theft Loss	(788)	21	4
5	Non-allowable Marketing Expenses	(1,520)	21	5
6	Non-allowable Legal	(27,787)	19	6
7	Annual Report	(250)	20	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(31,336)		49

South Suburban Rehabilitation Center

ID# 0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			250		1,849	939	17					3,055	1
2	Food Purchase	(174)		266									92	2
3	Housekeeping			248		28		(2,200)					(1,924)	3
4	Laundry							(23)					(23)	4
5	Heat and Other Utilities			1,523		63	131						1,717	5
6	Maintenance			1,926	3,718	8	22						5,674	6
7	Other (specify):*				1,461	240							1,701	7
8	TOTAL General Services	(174)		4,213	5,179	2,188	1,092	(2,206)					10,292	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(93)				15,939		(9,404)					6,442	10
10a	Therapy					1,364							1,364	10a
11	Activities													11
12	Social Services					7,817							7,817	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,846							5,846	15
16	TOTAL Health Care and Programs	(93)				30,966		(9,404)					21,469	16
	C. General Administration													
17	Administrative			1,212	4,506	22,931	1,877						30,526	17
18	Directors Fees													18
19	Professional Services	(27,787)		2,451		751	72						(24,513)	19
20	Fees, Subscriptions & Promotions	(7,166)		3,329		5	64	(235)					(4,003)	20
21	Clerical & General Office Expenses	(283,192)		14,498	70,289	7,785	2,225			(5,969)			(194,364)	21
22	Employee Benefits & Payroll Taxes				(6,774)	(2,596)							(9,370)	22
23	Inservice Training & Education													23
24	Travel and Seminar			860		101							961	24
25	Other Admin. Staff Transportation			720			123						843	25
26	Insurance-Prop.Liab.Malpractice			536		9	152						697	26
27	Other (specify):*				12,692	3,969	518						17,179	27
28	TOTAL General Administration	(318,145)		23,606	80,713	32,955	5,031	(235)		(5,969)			(182,044)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(318,413)		27,819	85,892	66,109	6,123	(11,845)		(5,969)			(150,284)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	47,555	245,664	6,254		493	139			4,072			304,177	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		259,556	18,682		3,470	427			947			283,082	32
33	Real Estate Taxes		239,580	2,348		102							242,030	33
34	Rent-Facility & Grounds		(660,000)	1,789			450						(657,761)	34
35	Rent-Equipment & Vehicles			584			43						627	35
36	Other (specify):*		166,700										166,700	36
37	TOTAL Ownership	47,555	251,500	29,657		4,065	1,059			5,019			338,855	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(9,351)						(9,351)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(9,351)						(9,351)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(270,858)	251,500	57,476	85,892	70,174	(2,169)	(11,845)		(950)			179,220	45

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 660,000	Homewood Mercy Property, LLC	100.00%	\$	\$ (660,000)	1
2	V	32 Interest		Homewood Mercy Property, LLC	100.00%	259,556	259,556	2
3	V	33 RE Taxes		Homewood Mercy Property, LLC	100.00%	239,580	239,580	3
4	V	36 Amortization		Homewood Mercy Property, LLC	100.00%	166,700	166,700	4
5	V	30 Depreciation		Homewood Mercy Property, LLC	100.00%	245,664	245,664	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		\$ 660,000			\$ 911,500	\$ * 251,500	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center# 0048678Report Period Beginning: 01/01/08Ending: 12/31/08

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	01	Dietary		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	\$ 250	\$ 250	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	266	266	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	248	248	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,523	1,523	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,926	1,926	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,212	1,212	20	
21	V	19	Professional Fees	6,490	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,941	2,451	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,329	3,329	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	14,498	14,498	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	860	860	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	720	720	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	536	536	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,254	6,254	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	18,682	18,682	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,348	2,348	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,789	1,789	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	584	584	31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 6,490			\$ 63,966	\$ *	57,476	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 Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,718	\$	3,718	15
16	V	06 Maintenance (Direct)	2,756	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,756			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,201		1,201	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	260		260	18
19	V	17 Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,506		4,506	19
20	V	21 Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	70,289		70,289	20
21	V	21 Office and Clerical (Direct)	16,400	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	16,400			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	11,181		11,181	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,511		1,511	23
24	V	22 Employee Benefits	6,774	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			(6,774)	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		\$ 25,930			\$ 111,822	\$ *	85,892	39

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

Facility Name & ID Number South Suburban Rehabilitation Center# 0048678Report Period Beginning: 01/01/08Ending: 12/31/08

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		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	4 Amount	Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	\$ 28	\$ 28	15
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	63	63	16
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	8	8	17
18	V	19	Professional Fees		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	751	751	18
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	5	5	19
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	123	123	20
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	101	101	21
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9	9	22
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	493	493	23
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,470	3,470	24
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	102	102	25
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,849	1,849	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	240	240	27
28	V	10	Nursing Salary	25,274	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	41,213	15,939	28
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,364	1,364	29
30	V	12	Social Service Salary	2,337	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	10,154	7,817	30
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	5,846	5,846	31
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	22,931	22,931	32
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7,662	7,662	33
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,969	3,969	34
35	V	22	Employee Benefits	2,596	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%		(2,596)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,207			\$ 100,381	\$ * 70,174	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center# 0048678Report Period Beginning: 01/01/08Ending: 12/31/08

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	01	Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,162	\$ 1,162	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%	131	131	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	22	22	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	72	72	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	64	64	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	285	285	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	123	123	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	152	152	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	139	139	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	427	427	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	450	450	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	43	43	28	
29	V	01	Dietary	353	Care Centers Health Systems, Inc.	100.00%	130	(223)	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	14,815	Care Centers Health Systems, Inc.	100.00%	5,464	(9,351)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	1,877	1,877	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,940	1,940	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	518	518	38	
39	Total			\$ 15,168			\$ 12,999	\$ * (2,169)	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	1 Dietary	\$ (188)	Xcel Supply, LLC	100.00%	\$ (171)	17	15	
16	V	3 Housekeeping	24,832	Xcel Supply, LLC	100.00%	22,632	(2,200)	16	
17	V	4 Laundry	259	Xcel Supply, LLC	100.00%	236	(23)	17	
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18	
19	V	10 Nursing	106,169	Xcel Supply, LLC	100.00%	96,765	(9,404)	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	2,657	Xcel Supply, LLC	100.00%	2,422	(235)	22	
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23	
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24	
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25	
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 133,728			\$ 121,883	\$ *	(11,845)	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%	\$ 33,991	\$ 33,991	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	33,991	CCS Employee Benefits Group	100.00%		(33,991)	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			\$ 33,991			\$ 33,991	\$ *	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	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$		15
16	V	21 Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%			17
18	V	26 Insurance		Vent Lease, LLC.	100.00%			18
19	V	30 Depreciation		Vent Lease, LLC.	100.00%			19
20	V	32 Interest		Vent Lease, LLC.	100.00%			20
21	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	4,072	4,072	21
22	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	947	947	22
23	V	21 Office and Clerical	5,969	Vent Lease, LLC.	100.00%		(5,969)	23
24	V	39 Ancillary		Vent Lease, LLC.	100.00%			24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 5,969			\$ 5,019	\$ * (950)	39

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

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	Shareholder	Administrative	99.00%	See Attached	0.61	1.83%		\$		1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.01	1.84%	Alloc. Salary	2,807	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.26	0.65%	Alloc. Salary	468	21-7	3
4	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.11	0.66%	Alloc. Salary	95	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,370		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 Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

1	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	01	Dietary	Patient Days	1,635,146	31	\$ 13,778	\$ 30,078	\$ 250	1
2	02	Food	Patient Days	1,635,146	31	13,971	30,078	266	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	30,078	248	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	30,078	1,523	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	30,078	1,926	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	30,078	1,212	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	30,078	8,941	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	30,078	3,329	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	30,078	14,498	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	30,078	860	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	30,078	720	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	30,078	536	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	30,078	6,254	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	30,078	18,682	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	30,078	2,348	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	30,078	1,789	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	30,078	584	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 63,966	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

1	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	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	30,078	3,718	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		2,756	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		30,078	1,201	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			260	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	30,078	4,506	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	30,078	70,289	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		16,400	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		30,078	11,181	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			1,511	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					\$ 6,211,280	\$ 5,395,924		\$ 111,822	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Center Clinical/Extended Care Clinical
 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	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 30,078	\$ 28	1	
2	05	Utilities	Patient Days	1,635,146	31	3,449	30,078	63	2	
3	06	Maintenance	Patient Days	1,635,146	31	431	30,078	8	3	
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	30,078	751	4	
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	30,078	5	5	
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	30,078	123	6	
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	30,078	101	7	
8	26	Insurance	Patient Days	1,635,146	31	465	30,078	9	8	
9	30	Depreciation	Patient Days	1,635,146	31	25,565	30,078	493	9	
10	32	Interest	Patient Days	1,635,146	31	191,164	30,078	3,470	10	
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	30,078	102	11	
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	30,078	1,849	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	30,078	240	13	
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	30,078	15,858	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	30,078	1,364	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	30,078	7,817	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	30,078	3,250	17	
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	30,078	22,931	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	30,078	7,662	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	30,078	3,969	20	
21	10	Nursing Salary	Direct Allocation			401,447	401,447		25,355	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016		2,337	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816			2,596	23
24										24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 100,381		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Centers Health Systems, Inc.
 Street Address 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

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	01	Dietary	Gross Billable Income	31	111,096		40,436	1,162	1
2	03	Housekeeping	Gross Billable Income	31			40,436		2
3	05	Heat and Other Utilities	Gross Billable Income	31	12,529		40,436	131	3
4	06	Maintenance	Gross Billable Income	31	2,136		40,436	22	4
5	19	Professional Fees	Gross Billable Income	31	6,873		40,436	72	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	6,095		40,436	64	6
7	21	Clerical and General Office	Gross Billable Income	31	27,280		40,436	285	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	11,773		40,436	123	8
9	26	Insurance	Gross Billable Income	31	14,568		40,436	152	9
10	30	Depreciation	Gross Billable Income	31	13,298		40,436	139	10
11	32	Interest	Gross Billable Income	31	40,850		40,436	427	11
12	33	Real Estate Taxes	Gross Billable Income	31			40,436		12
13	34	Rent - Building	Gross Billable Income	31	43,000		40,436	450	13
14	35	Rent - Equipment	Gross Billable Income	31	4,135		40,436	43	14
15	01	Dietary	Direct Billable Income	31	102,965		353	130	15
16	02	Food	Direct Billable Income	31	1,612				16
17	03	Housekeeping	Direct Billable Income	31					17
18	10	Nursing	Direct Billable Income	31					18
19	21	Clerical and General Office	Direct Billable Income	31					19
20	25	Other Admin. Staff Transport.	Direct Billable Income	31					20
21	39	Ancillary	Direct Billable Income	31	1,321,550		14,815	5,464	21
22	17	Administrative	Gross Billable Income	31	179,474	179,474	40,436	1,877	22
23	21	Clerical and General Office	Gross Billable Income	31	185,549	185,549	40,436	1,940	23
24	27	Employee Benefits	Gross Billable Income	31	49,573		40,436	518	24
25	TOTALS				\$ 2,134,357	\$ 365,023		\$ 12,999	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		(171)	1
2	3	Housekeeping	Direct Allocation					22,632	2
3	4	Laundry	Direct Allocation					236	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					96,765	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation					2,422	8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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				\$	\$		121,883	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		\$ 33,991	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				\$	\$		\$ 33,991	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	06	Repairs	Direct Billing	669,310	26	\$ 79,460		\$	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933			2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473			3
4	26	Insurance	Direct Billing	669,310	26	1,630			4
5	30	Depreciation	Direct Billing	669,310	26	264,263			5
6	32	Interest	Direct Billing	669,310	26	44,568			6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	30,078		4,072
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	30,078		947
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					\$ 672,138	\$	\$	5,019

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending: 12/31/08

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			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle Bank		X	Mortgage			\$	6,140,424		\$	259,556	1								
2	LaSalle Bank		X	Loan Payable				443,736				2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Lake Forest Bank		X								78,694	6								
7	LaSalle Bank		X								3,136	7								
8	See Supplemental Schedule										134,695	8								
9	TOTAL Facility Related						\$	6,584,160		\$	476,080	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$			\$		14								
15	TOTALS (line 9+line14)						\$	6,584,160		\$	476,080	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.)

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Cole Taylor Bank		X							\$ 23,062										
9	The Private Bank& Trust		X							41,144										
10	Bank Leumi		X							46,963										
11	Alloc from Care Centers/Ext Care		X							22,152										
12	Alloc from Care Centers Health System		X							427										
13	Alloc from Vent Lease		X							947										
14	TOTAL Working Capital									134,695										
B. Non-Facility Related*																				
15																				
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related																			

* 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation 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 2007 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 2007.

(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. <u>32-05-400-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>172,220.21</u>	\$ <u>172,220.21</u>
2. <u>See Attached</u>	<u>2201 Main LLC</u>	\$ <u>122,122.75</u>	\$ <u>1,004.24</u>
3. <u>See Attached</u>	<u>Care Centers Building, LLC</u>	\$ <u>43,667.89</u>	\$ <u>534.82</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>338,010.85</u>	\$ <u>173,759.27</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation 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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 Rehabilitation Center

0048678 Report Period Beginning:

01/01/08 Ending:

12/31/08

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	<u>Facility</u>		<u>2007</u>	\$ <u>600,000</u>	1
2	<u>Allocated From CCI/ECC</u>			<u>6,882</u>	2
3	TOTALS			\$ 606,882	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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
	Improvement Type**										
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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	245,664		91,314	(154,350)	182,628	67
68		38,228	2,025		2,025		13,180	68
69			31,859			(31,859)		69
70		\$ 3,234,228	\$ 279,548		\$ 93,339	\$ (186,209)	\$ 195,808	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	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 12A, Carried Forward		\$ 3,234,228	\$ 279,548		\$ 93,339	\$ (186,209)	\$ 195,808	1
2	Replace Walk-In Cooler Doors	2007	4,750		20	679	679	1,018	2
3	Remove 15 Doors	2007	10,000		20	500	500	708	3
4	Smoke Detector	2007	9,691		20	1,384	1,384	1,846	4
5	Preventer, 8000-F Strainer & Acces.	2007	5,365		20	268	268	313	5
6	Painting (Transfer Expense From Home Office)	2007	19,621		20	4,905	4,905	19,621	6
7	Painting (Transfer Expense From Home Office)	2007	22,946		20	21,034	21,034	22,946	7
8	Roof Repair	2007	2,500		20	125	125	188	8
9	Backflow Preventer Installation	2008	5,365		20	268	268	268	9
10	Install Floor In Walk-In Freezer	2008	3,600		20	180	180	180	10
11	Exterior Street Sign - Double Faced	2008	7,716		20	514	514	514	11
12	Exterior Street Sign	2008	8,941		20	596	596	596	12
13	Security System	2008	3,380		20	99	99	99	13
14	New Laundry Room 2Nd Floor	2008	2,530		20	53	53	53	14
15	Install New Metal Doors With Frame	2008	3,750		20	31	31	31	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12E, Carried Forward	\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189		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)	\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189		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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12F, Carried Forward		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12I, Carried Forward		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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)		\$ 3,344,383	\$ 279,548		\$ 123,975	\$ (155,573)	\$ 244,189	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 182,628	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Current Book Depreciation					245,664			(245,664)		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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	TOTAL (lines 4 thru 69)	\$	3,196,000	\$	245,664	\$	91,314	\$	(154,350)	\$	182,628	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocated from EC/CC Clinical, Inc.		2002	2002	\$ 968	\$ 25	39	\$ 25		\$ 156	4
5	Allocated from CCI/ECC - CCI Building			1996	12,502	321	39	321		3,860	5
6	Allocated from CCI/Extended Care Consulting, LLC		2002	2002	7,543	193	39	193		1,217	6
7											7
8											8
	Improvement Type**										
9	Allocated from CCI/Extended Care Consulting, LLC			2002	6,231	569	20	569		2,853	9
10	Allocated from CCI/Extended Care Consulting, LLC			2003	7,343	671	20	671		3,362	10
11	Allocated from CCI/Extended Care Consulting, LLC			2005	365	39	20	39		93	11
12	Allocated from CCI/Extended Care Consulting, LLC			2007	76	4	20	4		9	12
13											13
14	Allocated from CCI/ECC- CCI Building			1996	211	-	20	-		211	14
15	Allocated from CCI/ECC- CCI Building			1997	1,201	39	20	39		610	15
16											16
17	Allocated from CC/EC Clinical, Inc.			2002	799	73	20	73		366	17
18	Allocated from CC/EC Clinical, Inc.			2003	942	86	20	86		431	18
19	Allocated from CC/EC Clinical, Inc.			2005	47	5	20	5		12	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 Rehabilitation Center

0048678

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			38,228		2,025		2,025	13,180

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 Rehabilitation Center # 0048678 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 49,804	\$ 7,723	\$ 3,651	\$ (4,072)	10	\$ 48,620	71
72	Current Year Purchases	2,072,239	17	207,217	207,200	10	414,417	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,122,043	\$ 7,740	\$ 210,868	\$ 203,128		\$ 463,037	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		Allocated from CCC/EC Clinical	2008	\$ 1,386	\$ 277	\$ 277	\$	5	\$ 539	76
77		Allocated from CCI/ECC	2008	14,325	890	890		5	12,316	77
78		Allocated from CC Health Sys	2008	132	26	26		5	31	78
79										79
80	TOTALS			\$ 15,843	\$ 1,193	\$ 1,193	\$		\$ 12,886	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)		\$ 6,089,151	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 288,481	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 336,036	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 47,555	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 720,112	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	<u>Alloc from Care Centers/Ext. Care Consult., LLC</u>				<u>1,789</u>			5
6	<u>Alloc from Care Centers Health Systems</u>				<u>450</u>			6
7	TOTAL				\$ 2,239			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.	<u> /2009</u>	\$ _____
13.	<u> /2010</u>	\$ _____
14.	<u> /2011</u>	\$ _____

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: \$ 3,932 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$		\$ 2,157	\$		\$ 2,157	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			10,818			10,818	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				3,772		3,772	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						27,412		27,412	13
14	TOTAL			\$		\$ 12,975	\$ 31,184		\$ 44,159	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 Rehabilitation Center# 0048678Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$ 2,601	1
2	Cash-Patient Deposits	26,932	26,932	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	708,216	708,216	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	417	417	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(395,391)	(210,513)	8
9	Other(specify): <u>See Attached Schedule</u>	931	931	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 341,605	\$ 528,584	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		3,196,000	14
15	Leasehold Improvements, at Historical Cost	109,155	109,155	15
16	Equipment, at Historical Cost	4,750	2,076,750	16
17	Accumulated Depreciation (book methods)	(31,859)	(2,847,817)	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>		1,226,665	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 82,046	\$ 4,360,753	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 423,651	\$ 4,889,337	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 212,034	\$ 212,034	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,527	19,527	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,137	151,137	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,305	25,305	31
32	Accrued Real Estate Taxes(Sch.IX-B)	900,000	1,253,001	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	6,235,137	9,196,511	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,543,140	\$ 10,857,515	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		443,736	39
40	Mortgage Payable		6,140,424	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,584,160	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,543,140	\$ 17,441,675	46
47	TOTAL EQUITY (page 18, line 24)	\$ (7,119,489)	\$ (12,552,338)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 423,651	\$ 4,889,337	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,367,837)	1
2	Restatements (describe):		2
3	<u>Restatement</u>	(3,756,785)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,124,622)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,994,867)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,994,867)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (7,119,489)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center# 0048678Report Period Beginning: 01/01/08Ending: 12/31/08**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,425,984	1
2	Discounts and Allowances for all Levels	(18,096)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,407,888	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	931	6
7	Oxygen	3,814	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,745	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,600	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	16,360	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,960	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	932	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 932	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,431,525	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,198,539	31
32	Health Care	2,269,999	32
33	General Administration	1,433,341	33
B. Capital Expense			
34	Ownership	1,338,163	34
C. Ancillary Expense			
35	Special Cost Centers	44,159	35
36	Provider Participation Fee	142,191	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,426,392	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,994,867)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,994,867)	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 Rehabilitation Center

0048678

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	2,095	2,378	\$ 99,941	\$ 42.03	1
2	Assistant Director of Nursing	607	685	22,041	32.18	2
3	Registered Nurses	1,793	3,222	67,174	20.85	3
4	Licensed Practical Nurses	33,263	36,898	883,193	23.94	4
5	CNAs & Orderlies	58,468	65,494	666,940	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,750	8,688	125,229	14.41	8
9	Activity Director	987	1,062	13,723	12.92	9
10	Activity Assistants	9,934	10,939	94,891	8.67	10
11	Social Service Workers	3,891	3,713	83,287	22.43	11
12	Dietician					12
13	Food Service Supervisor	2,014	2,220	37,898	17.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,039	4,652	57,662	12.40	15
16	Dishwashers	10,715	12,159	124,476	10.24	16
17	Maintenance Workers	7,327	8,161	127,518	15.63	17
18	Housekeepers	13,685	15,252	171,159	11.22	18
19	Laundry	6,923	7,881	85,402	10.84	19
20	Administrator	1,699	1,865	72,314	38.77	20
21	Assistant Administrator	976	1,080	28,827	26.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,535	7,568	82,342	10.88	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	1,567	1,909	24,059	12.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,124	1,203	15,250	12.68	33
34	TOTAL (lines 1 - 33)	175,392	197,029	\$ 2,883,326 *	\$ 14.63	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	131	\$ 6,167	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,750	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	50	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	200	11-03	44
45	Social Service Consultant	56			45
46	Other(specify)				46
47	<u>See Attached</u>		25,274	10-03	47
48	<u>See Attached</u>		2,337	12-03	48
49	TOTAL (lines 35 - 48)	192	\$ 42,778		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	12	\$ 682	10-03	50
51	Licensed Practical Nurses	24	872	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	36	\$ 1,554		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

Report Period Beginning: 01/01/08 Ending:

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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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

Facility Name & ID Number South Suburban Rehabilitation Center

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 \$3108
- (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? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,902 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. \$ 142,191
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?
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