

Facility Name & ID Number South Suburban Rehabilitation Center

0048678 Report Period Beginning: 01/01/09 Ending: 12/31/09

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>94,535</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>94,535</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>24,321</u>	<u>2,505</u>	<u>2,744</u>	<u>29,570</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>24,321</u>	<u>2,505</u>	<u>2,744</u>	<u>29,570</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 31.28%

D. How many bed-hold days during this year were paid by the Department? N/A (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 259 and days of care provided 2,744

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	217,919	34,236	6,970	259,125		259,125	5,010	264,135		1
2	Food Purchase		150,893		150,893		150,893	196	151,089		2
3	Housekeeping	152,735	32,896		185,631		185,631	(2,419)	183,212		3
4	Laundry	70,522	10,880		81,402		81,402	(343)	81,059		4
5	Heat and Other Utilities			172,051	172,051		172,051	1,504	173,555		5
6	Maintenance	134,779		77,951	212,730		212,730	6,748	219,478		6
7	Other (specify):*							1,481	1,481		7
8	TOTAL General Services	575,955	228,905	256,972	1,061,832		1,061,832	12,176	1,074,008		8
	B. Health Care and Programs										
9	Medical Director			22,500	22,500		22,500	(4,500)	18,000		9
10	Nursing and Medical Records	1,809,455	109,476	17,620	1,936,551		1,936,551	9,172	1,945,723		10
10a	Therapy	112,824			112,824		112,824	1,562	114,386		10a
11	Activities	97,933	10,852	200	108,985		108,985		108,985		11
12	Social Services	121,086		2,438	123,524		123,524	4,127	127,651		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,330	5,330		15
16	TOTAL Health Care and Programs	2,141,298	120,328	42,758	2,304,384		2,304,384	15,692	2,320,076		16
	C. General Administration										
17	Administrative	116,024			116,024		116,024	34,316	150,340		17
18	Directors Fees										18
19	Professional Services			155,058	155,058	(67,639)	87,419	(17,086)	70,333		19
20	Dues, Fees, Subscriptions & Promotions			25,415	25,415		25,415	(7,270)	18,145		20
21	Clerical & General Office Expenses	86,692	17,134	491,175	595,001		595,001	(332,177)	262,824		21
22	Employee Benefits & Payroll Taxes			541,655	541,655		541,655	(8,136)	533,519		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,910	5,910		5,910	620	6,530		24
25	Other Admin. Staff Transportation			2,870	2,870		2,870	374	3,244		25
26	Insurance-Prop.Liab.Malpractice			285,997	285,997		285,997	(74,022)	211,975		26
27	Other (specify):*							22,726	22,726		27
28	TOTAL General Administration	202,716	17,134	1,508,080	1,727,930	(67,639)	1,660,291	(380,655)	1,279,636		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,919,969	366,367	1,807,810	5,094,146	(67,639)	5,026,507	(352,787)	4,673,720		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,680	9,680		9,680	91,631	101,311			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,852	164,852		164,852	35,093	199,945			32
33	Real Estate Taxes			180,831	180,831	67,639	248,470	1,327	249,797			33
34	Rent-Facility & Grounds							3,819	3,819			34
35	Rent-Equipment & Vehicles			6,759	6,759		6,759	1,485	8,244			35
36	Other (specify):*											36
37	TOTAL Ownership			362,122	362,122	67,639	429,761	133,355	563,116			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		151,132	384,389	535,521		535,521	(24,579)	510,942			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,803	141,803		141,803		141,803			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		151,132	526,192	677,324		677,324	(24,579)	652,745			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,919,969	517,499	2,696,124	6,133,592		6,133,592	(244,011)	5,889,581			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

South Suburban Rehabilitation Center

ID# 0048678

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Miscellaneous Income	\$ (522)	21	1
2	Jury Duty	(17)	10	2
3	Theft Loss	(844)	21	3
4	Non-Allowable Marketing Expenses	(300)	19	4
5	Non-Allowable Legal	(15,841)	19	5
6	Annual Report	(500)	20	6
7	Collection Expense	(911)	21	7
8	Prior Period ADJ - Medical Director	(4,500)	09	8
9	Prior Period ADJ - Insurance Premium ADJ	(74,501)	26	9
10	Prior Period ADJ - Prepaid Insurance	(416)	26	10
11	Non-Allowable Interest Expense	(8,613)	32	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	(106,965)		49

South Suburban Rehabilitation Center

ID# 0048678

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			145		2,525	(17)				2,357		5,010	1
2	Food Purchase	(128)		324									196	2
3	Housekeeping			302		33	(2,754)						(2,419)	3
4	Laundry						(343)						(343)	4
5	Heat and Other Utilities			1,239		79					186		1,504	5
6	Maintenance			1,923	4,710	10	(37)				142		6,748	6
7	Other (specify):*				1,115	366							1,481	7
8	TOTAL General Services	(128)		3,933	5,825	3,013	(3,152)				2,685		12,176	8
	B. Health Care and Programs													
9	Medical Director	(4,500)											(4,500)	9
10	Nursing and Medical Records	(17)				18,031	(8,140)				(702)		9,172	10
10a	Therapy					988				574			1,562	10a
11	Activities													11
12	Social Services					4,474	(347)						4,127	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,330							5,330	15
16	TOTAL Health Care and Programs	(4,517)				28,823	(8,486)			574	(702)		15,692	16
	C. General Administration													
17	Administrative			1,418	5,142	22,421					5,335		34,316	17
18	Directors Fees													18
19	Professional Services	(16,141)		(1,834)		690					199		(17,086)	19
20	Fees, Subscriptions & Promotions	(8,570)		1,214		5					81		(7,270)	20
21	Clerical & General Office Expenses	(423,005)		9,935	77,343	5,028			(7,935)		6,457		(332,177)	21
22	Employee Benefits & Payroll Taxes				(4,724)	(3,412)							(8,136)	22
23	Inservice Training & Education													23
24	Travel and Seminar			38		582							620	24
25	Other Admin. Staff Transportation			222							152		374	25
26	Insurance-Prop.Liab.Malpractice	(74,917)		487		29					379		(74,022)	26
27	Other (specify):*				16,503	3,895					2,328		22,726	27
28	TOTAL General Administration	(522,633)		11,480	94,264	29,238			(7,935)		14,931		(380,655)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(527,278)		15,413	100,089	61,074	(11,638)		(7,935)	574	16,914		(352,787)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Suburban Rehabilitation Center# 0048678

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	81,750		2,483		550			6,458		390		91,631	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,216)		36,499		6,643			1,167				35,093	32
33	Real Estate Taxes			1,197		130							1,327	33
34	Rent-Facility & Grounds			2,077							1,742		3,819	34
35	Rent-Equipment & Vehicles			1,466							19		1,485	35
36	Other (specify):*													36
37	TOTAL Ownership	72,534		43,722		7,323			7,625		2,151		133,355	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,520)			(18,876)	(4,183)		(24,579)	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						(1,520)			(18,876)	(4,183)		(24,579)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(454,744)		59,135	100,089	68,397	(13,158)		(310)	(18,302)	14,882		(244,011)	45

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 Properties, 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		\$	See Attached		\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* 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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 145	\$	145	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	324		324	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	302		302	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,239		1,239	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	1,923		1,923	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,418		1,418	20
21	V	19 Professional Fees	7,969	Extended Care Consulting, LLC	100.00%	6,135		(1,834)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,214		1,214	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	9,935		9,935	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	38		38	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	222		222	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	487		487	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,483		2,483	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	36,499		36,499	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,197		1,197	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	2,077		2,077	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,466		1,466	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 7,969			\$ 67,104	\$ *	59,135	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 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,710	\$	4,710	15
16	V	06 Maintenance (Direct)	2,039	Extended Care Consulting, LLC	100.00%	2,039			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	806		806	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	309		309	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	5,142		5,142	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	77,343		77,343	20
21	V	21 Office and Clerical (Direct)	21,579	Extended Care Consulting, LLC	100.00%	21,579			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	13,233		13,233	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,270		3,270	23
24	V	22 Employee Benefits	4,724	Extended Care Consulting, LLC	100.00%			(4,724)	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		\$ 28,342			\$ 128,431	\$ *	100,089	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 33	\$	33	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	79		79	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	10		10	17
18	V	19 Professional Fees		Extended Care Clinical, LLC	100.00%	690		690	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	5		5	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	587		587	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	582		582	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	29		29	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	550		550	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	6,643		6,643	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	130		130	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	2,525		2,525	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	366		366	27
28	V	10 Nursing Salary	14,620	Extended Care Clinical, LLC	100.00%	32,651		18,031	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	988		988	29
30	V	12 Social Service Salary	2,438	Extended Care Clinical, LLC	100.00%	6,912		4,474	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,330		5,330	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	22,421		22,421	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	4,441		4,441	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	3,895		3,895	34
35	V	22 Employee Benefits	3,412	Extended Care Clinical, LLC	100.00%			(3,412)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 20,470			\$ 88,867	\$ *	68,397	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 188	Xcel Supply, LLC	100.00%	\$ 171	\$ (17)
16	V	3 Housekeeping	29,990	Xcel Supply, LLC	100.00%	27,236	(2,754)
17	V	4 Laundry	3,739	Xcel Supply, LLC	100.00%	3,396	(343)
18	V	6 Repairs & Maintenance	404	Xcel Supply, LLC	100.00%	367	(37)
19	V	10 Nursing	88,637	Xcel Supply, LLC	100.00%	80,498	(8,140)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service	3,773	Xcel Supply, LLC	100.00%	3,427	(347)
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%		
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	16,552	Xcel Supply, LLC	100.00%	15,032	(1,520)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 143,283			\$ 130,125	\$ * (13,158)

* 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%	\$ 55,457	\$ 55,457	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	55,457	CCS Employee Benefits Group	100.00%		(55,457)	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		\$ 55,457			\$ 55,457	\$ *	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	19 Professional Fees		Vent Lease, LLC.	100.00%			16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%			17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%			18
19	V	26 Insurance		Vent Lease, LLC.	100.00%			19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%			20
21	V	32 Interest		Vent Lease, LLC.	100.00%			21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	6,458	6,458	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,167	1,167	23
24	V	21 Office and Clerical	7,935	Vent Lease, LLC.	100.00%		(7,935)	24
25	V	39 Ancillary		Vent Lease, LLC.	100.00%			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		\$ 7,935			\$ 7,625	\$ * (310)	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	39 THERAPY	\$ 360,973	TRICARE REHAB		\$ 342,097	\$ (18,876)
16	V	10A REHAB				574	574
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 360,973			\$ 342,671	\$ * (18,302)

* 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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 2,457	\$	2,457	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%	186		186	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	142		142	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	199		199	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	81		81	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,010		1,010	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	152		152	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	379		379	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	390		390	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%				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%	1,742		1,742	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	19		19	28
29	V	01 Dietary	166	Care Centers Health Systems, Inc.	100.00%	66		(100)	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	1,169	Care Centers Health Systems, Inc.	100.00%	467		(702)	32
33	V	22 Employee Benefits		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	6,963	Care Centers Health Systems, Inc.	100.00%	2,780		(4,183)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	5,335		5,335	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	5,447		5,447	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	2,328		2,328	38
39	Total		\$ 8,298			\$ 23,180	\$ *	14,882	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	51.00%	See Attached	0.64	1.38%		\$		1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.18	2.15%	Alloc. Salary	3,578	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.32	0.80%	Alloc. Salary	582	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,160		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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 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	30	\$ 6,770	\$	29,570	\$ 145	1
2	02	Food	Patient Days	30	15,058		29,570	324	2
3	03	Housekeeping	Patient Days	30	14,059		29,570	302	3
4	05	Utilities	Patient Days	30	57,646		29,570	1,239	4
5	06	Maintenance	Patient Days	30	89,465		29,570	1,923	5
6	17	Administrative	Patient Days	30	66,000		29,570	1,418	6
7	19	Professional Fees	Patient Days	30	285,482		29,570	6,135	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		29,570	1,214	8
9	21	Office and Clerical	Patient Days	30	462,313		29,570	9,935	9
10	24	Seminar and Travel	Patient Days	30	1,768		29,570	38	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		29,570	222	11
12	26	Insurance	Patient Days	30	22,668		29,570	487	12
13	30	Depreciation	Patient Days	30	115,549		29,570	2,483	13
14	32	Interest	Patient Days	30	1,698,489		29,570	36,499	14
15	33	Real Estate Taxes	Patient Days	30	55,709		29,570	1,197	15
16	34	Rent - Building	Patient Days	30	96,636		29,570	2,077	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		29,570	1,466	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 67,104	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	1,376,056	30	219,177	219,177	29,570	4,710	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905		2,039	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		29,570	806	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464		309	4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	29,570	5,142	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	29,570	77,343	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			21,579	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	29,570	13,233	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	29,570	3,270	9
10	22	Employee Benefits								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,530,203	\$ 4,838,529		\$ 128,431	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Clinical 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	03	Housekeeping	Patient Days	1,376,056	30	\$ 1,549	\$ 29,570	\$ 33	1
2	05	Utilities	Patient Days	1,376,056	30	3,693	29,570	79	2
3	06	Maintenance	Patient Days	1,376,056	30	477	29,570	10	3
4	19	Professional Fees	Patient Days	1,376,056	30	32,105	29,570	690	4
5	20	Dues and Subscriptions	Patient Days	1,376,056	30	213	29,570	5	5
6	21	Office & Clerical	Patient Days	1,376,056	30	27,296	29,570	587	6
7	24	Travel and Seminar	Patient Days	1,376,056	30	27,079	29,570	582	7
8	26	Insurance	Patient Days	1,376,056	30	1,342	29,570	29	8
9	30	Depreciation	Patient Days	1,376,056	30	25,586	29,570	550	9
10	32	Interest	Patient Days	1,376,056	30	309,136	29,570	6,643	10
11	33	Real Estate Taxes	Patient Days	1,376,056	30	6,053	29,570	130	11
12	01	Dietary Salary	Patient Days	1,376,056	30	117,506	29,570	2,525	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,376,056	30	17,040	29,570	366	13
14	10	Nursing Salary	Patient Days	1,376,056	30	799,889	29,570	17,189	14
15	10a	Rehab Salary	Patient Days	1,376,056	30	45,993	29,570	988	15
16	12	Social Service Salary	Patient Days	1,376,056	30	247,396	29,570	5,316	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,376,056	30	158,537	29,570	3,407	17
18	17	Administration Salary	Patient Days	1,376,056	30	1,043,375	29,570	22,421	18
19	21	Office Salary	Patient Days	1,376,056	30	206,680	29,570	4,441	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,376,056	30	181,271	29,570	3,895	20
21	10	Nursing Salary	Direct Allocation			494,488	29,570	15,462	21
22	12	Social Service Salary	Direct Allocation			196,033	29,570	1,596	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			82,560	29,570	1,923	23
24									24
25	TOTALS					\$ 4,025,296	\$ 3,151,360	\$ 88,867	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

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					27,236	2
3	4	Laundry	Direct Allocation					3,396	3
4	6	Repairs & Maintenance	Direct Allocation					367	4
5	10	Nursing	Direct Allocation					80,498	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation					3,427	7
8	20	Dues, Fees And Subscriptions	Direct Allocation						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					15,032	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				\$	\$		\$ 130,125	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 55,457	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				\$	\$		\$ 55,457	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	821,185	26	\$ 80,807		\$	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427			2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852			3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356			4
5	26	Insurance	Direct Billing	821,185	26	4,573			5
6	30	Depreciation	Direct Billing	821,185	26	218,810			6
7	32	Interest	Direct Billing	821,185	26	35,420			7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	29,570	6,458	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	29,570	1,167	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					\$ 706,114	\$	\$ 7,625	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 TriCare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		\$ 342,097	1
2	10A	REHAB	DIRECT ALLOCATION					574	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				\$	\$		\$ 342,671	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	3,421,940	26	72,652	115,708	2,457	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		115,708		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	115,708	186	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	115,708	142	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	115,708	199	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	115,708	81	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	115,708	1,010	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	115,708	152	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	115,708	379	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	115,708	390	10
11	32	Interest	Gross Billable Income	3,421,940	26		115,708		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		115,708		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	115,708	1,742	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	115,708	19	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445	166	66	15
16	02	Food	Direct Billable Income	2,784	26	1,111			16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182	1,169	467	18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	6,963	2,780	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	5,335	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	5,447	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	115,708	2,328	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 23,180	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

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										
										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	Bank Leumi		X							\$ 19,249	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	The Private Bank & Trust		X							35,353	6								
7	Lake Forest		X							71,625	7								
8	See Supplemental Schedule									74,322	8								
9	TOTAL Facility Related					\$	\$			\$ 200,548	9								
B. Non-Facility Related*																			
10	Interest Income		X							(603)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related					\$	\$			\$ (603)	14								
15	TOTALS (line 9+line14)					\$	\$			\$ 199,946	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending:

12/31/09

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							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term																			
	Working Capital																			
8	DIAWA		X	Line of Credit			\$	\$			\$	11,580	8							
9	Alloc from Ext Care Consult		X									36,499	9							
10	Alloc from Ext Care Clinical		X									6,643	10							
11	Alloc from Vent Lease		X									1,167	11							
12	Cole Taylor Bank		X									18,433	12							
13													13							
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$		15							
16													16							
17													17							
18													18							
19													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.)

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 (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	629,092	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	235,001	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(394,091)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	576,249	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	67,639	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 29,411 For 2006 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	249,797	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004		8	
	2005		9	
	2006	445,015	10	
	2007	172,220	11	
	2008	233,674	12	
Beginning real estate tax accrual has been adjusted to agree to the prior year ending accrual. The prior year ending accrual does not agree to the 2008 cost report due to a late journal entry.				
Alloc from Extended Care Consulting, LLC \$1,197				
Alloc from Extended Care Clinical \$130				
			FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility		2007	\$ 600,000	1
2	Allocated From ECC			7,887	2
3	TOTALS			\$ 607,887	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center

0048678

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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

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	Related Building Company (Pages 12F & 12G)	3,196,000			91,314	91,314	273,942	67
68	Related Party Allocations (Pages 12H & 12I)	31,204	2,131		2,131		12,982	68
69	Financial Statement Depreciation		9,680			(9,680)		69
70	TOTAL (lines 4 thru 69)	\$ 3,227,204	\$ 11,811		\$ 93,445	\$ 81,634	\$ 286,924	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		\$ 3,227,204	\$ 11,811		\$ 93,445	\$ 81,634	\$ 286,924	1
2	Replace Walk-In Cooler Doors	2007	4,750		20	679	679	1,696	2
3	Remove 15 Doors	2007	10,000		20	500	500	1,208	3
4	Smoke Detector	2007	9,691		20	1,384	1,384	3,230	4
5	Preventer, 8000-F Strainer & Acces.	2007	5,365		20	268	268	581	5
6	Roof Repiar	2007	2,500		20	125	125	313	6
7	Backflow Preventer Installation	2008	5,365		20	268	268	537	7
8	Install Floor In Walk-In Freezer	2008	3,600		20	180	180	360	8
9	Exterior Street Sign - Double Faced	2008	7,716		20	514	514	1,029	9
10	Exterior Street Sign	2008	8,941		20	596	596	1,192	10
11	Security System	2008	3,380		20	169	169	268	11
12	New Laundry Room 2Nd Floor	2008	2,530		20	127	127	179	12
13	Install New Metal Doors With Frame	2008	3,750		20	188	188	219	13
14	Roofing	2008	2,500		20	125	125	250	14
15	Roofing	2008	900		20	45	45	90	15
16	Plumbing	2008	2,850		20	143	143	285	16
17	Smoke Dampers	2009	26,600		20	1,219	1,219	1,219	17
18	Security System For Front Door	2009	2,644		20	44	44	44	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)		\$ 3,330,286	\$ 11,811		\$ 100,019	\$ 88,208	\$ 299,624	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:

01/01/09

Ending:

12/31/09

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		\$ 3,330,286	\$ 11,811		\$ 100,019	\$ 88,208	\$ 299,624	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)		\$ 3,330,286	\$ 11,811		\$ 100,019	\$ 88,208	\$ 299,624	34

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	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		\$ 3,330,286	\$ 11,811		\$ 100,019	\$ 88,208	\$ 299,624	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)	\$ 3,330,286	\$ 11,811		\$ 100,019	\$ 88,208	\$ 299,624	34

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	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		\$ 3,330,286	\$ 11,811		\$ 100,019	\$ 88,208	\$ 299,624	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)	\$ 3,330,286	\$ 11,811		\$ 100,019	\$ 88,208	\$ 299,624	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	259 Bed Building	1976	3,196,000		35	91,314	91,314	273,942	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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	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		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)	\$ 3,196,000	\$		\$ 91,314	\$ 91,314	\$ 273,942	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	1,078	28	39	28		202	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	9,790	251	39	251		1,830	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2002	8,087	739	20	739		4,441	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2003	9,530	871	20	871		5,234	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2005	474	50	20	50		171	12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2009	85	4	20	4		4	13
14									14
15									15
16	Allocated from Extended Care Consulting, LLC	2007	99	2	20	2		12	16
17	Allocated from Extended Care Consulting, LLC	2009	59	3	20	3		3	17
18									18
19									19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	891	81	20	81		489	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,050	96	20	96		577	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	52	6	20	6		19	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	9		20				23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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	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								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 (12H & 12I lines 1 thru 33)	\$ 31,204	\$ 2,131		\$ 2,131	\$	\$ 12,982	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:

01/01/09

Ending:

12/31/09

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	\$ 4,964	\$ 6,954	\$ 496	\$ (6,458)	10	\$ 3,135	71
72	Current Year Purchases	1,800	180	180		10	180	72
73	Fully Depreciated Assets	2,132,909				10	2,132,909	73
74								74
75	TOTALS	\$ 2,139,673	\$ 7,134	\$ 676	\$ (6,458)		\$ 2,136,224	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		Alloc. From EC Clinical	2009	\$ 1,545	\$ 309	\$ 309		5	\$ 910	76
77		Alloc. From ECC	2009	6,910	108	108		5	6,586	77
78		Alloc. From CC Health Systems	2009	991	198	198		5	298	78
79										79
80	TOTALS			\$ 9,446	\$ 615	\$ 615			\$ 7,794	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)	\$ 6,087,292	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,560	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,310	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 81,750	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,443,642	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	Alloc from Extended Care Consulting, LLC			2,077			5
6	Alloc from Care Centers Health Systems			1,742			6
7	TOTAL			\$ 3,819			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 8,244 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

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

Facility Name & ID Number South Suburban Rehabilitation Center # 0048678 Report Period Beginning: 01/01/09 Ending: 12/31/09
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8	
			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	\$		\$	201,498	\$			\$	201,498	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				17,624					17,624	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				165,267					165,267	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescrpts						116,159			116,159	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): <u>See Supplemental</u>								34,973			34,973	13
14	TOTAL			\$		\$	384,389	\$	151,132	\$		535,521	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (125,369)	\$	1
2	Cash-Patient Deposits	17,516		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,090,724		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	235,057		6
7	Other Prepaid Expenses	995		7
8	Accounts Receivable (owners or related parties)	(645,391)		8
9	Other(specify): <u>See Attached Schedule</u>	28,675		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 602,207	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	93,188		15
16	Equipment, at Historical Cost	7,394		16
17	Accumulated Depreciation (book methods)	(17,584)		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>	111,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 193,998	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 796,205	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 962,445	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,746		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	256,322		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,211		31
32	Accrued Real Estate Taxes(Sch.IX-B)	576,249		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>	2,340,322		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,168,295	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,168,295	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,372,090)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 796,205	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,119,489)	1
2	Restatements (describe):		2
3	See Attached	4,732,430	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,387,059)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(985,031)	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)	\$ (985,031)	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)	\$ (3,372,090)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 4,995,997	1
2	Discounts and Allowances for all Levels	(1,258,945)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,737,052	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,299,048	6
7	Oxygen	2,171	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,301,219	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	117,762	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,345	20
21	Other Medical Services	(40,370)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 79,737	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	603	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 603	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	29,950	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,950	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,148,561	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,061,832	31
32	Health Care	2,304,384	32
33	General Administration	1,727,930	33
B. Capital Expense			
34	Ownership	362,122	34
C. Ancillary Expense			
35	Special Cost Centers	535,521	35
36	Provider Participation Fee	141,803	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,133,592	40
41	Income before Income Taxes (line 30 minus line 40)**	(985,031)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (985,031)	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:

01/01/09

Ending:

12/31/09

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	2,066	2,185	\$ 100,642	\$ 46.06	1
2	Assistant Director of Nursing	384	456	15,349	33.66	2
3	Registered Nurses	4,948	5,981	161,915	27.07	3
4	Licensed Practical Nurses	31,877	34,273	857,471	25.02	4
5	CNAs & Orderlies	57,482	66,099	616,293	9.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,310	7,238	112,824	15.59	8
9	Activity Director	139	145	1,838	12.68	9
10	Activity Assistants	9,725	10,478	96,095	9.17	10
11	Social Service Workers	5,191	5,761	121,086	21.02	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,283	40,160	17.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,048	4,631	59,111	12.76	15
16	Dishwashers	11,224	12,749	118,648	9.31	16
17	Maintenance Workers	7,284	8,427	134,779	15.99	17
18	Housekeepers	11,239	14,079	152,735	10.85	18
19	Laundry	5,107	6,424	70,522	10.98	19
20	Administrator	2,235	2,393	87,887	36.73	20
21	Assistant Administrator	1,176	1,208	28,137	23.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,320	7,364	86,692	11.77	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	1,698	1,983	28,974	14.61	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,133	2,259	28,810	12.75	33
34	TOTAL (lines 1 - 33)	172,594	196,416	\$ 2,919,968 *	\$ 14.87	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	171	\$ 6,970	01-03	35
36	Medical Director	Monthly	22,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,000	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	200	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>See Attached</u>	44	2,437	10-03	47
48	<u>See Attached</u>	93	14,620	12-03	48
49	TOTAL (lines 35 - 48)	312	\$ 49,727		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Nathan Goldman	Administrator		\$ 76,503	Workers' Compensation Insurance	\$ 96,638	IDPH License Fee	\$ 995	
Charles Slagle	Administrator		11,384	Unemployment Compensation Insurance	112,798	Advertising: Employee Recruitment		
Charles Slagle	Asst. Admin		28,137	FICA Taxes	218,647	Health Care Worker Background Check	5,372	
				Employee Health Insurance	83,298	(Indicate # of checks performed)	7,345	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscription	1,902	
				Employee Physical	25	Licenses & Fees	1,231	
				Pension Expenses	12,953	Alloc from Ext Care Consult.	1,214	
				Other Employee Welfare	7,435	Alloc from Ext Care Clinical	5	
				Holiday Expenses	1,550	Alloc from Care Centers Health Systems	81	
				Drug Testing Kits	176	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 116,024	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 533,520		\$ 18,146		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Seminar Expense	985
(Attach a copy of any management service agreement)							Inservice Expenses	4,925
C. Professional Services							Alloc from Ext Care Consult	38
Vendor/Payee	Type		Amount				Alloc from Ext Care Clinical	582
Frost, Ruttenberg&Rothblatt	Accounting		\$ 19,050				Entertainment Expense	()
Personnel Planners	Unemployment Consult.		1,986				(agree to Sch. V,	
Ext. Care Consulting	Home Office Expenses		4,119				line 24, col. 8)	
Ext. Care Consulting	Other Professional Fees		3,850				TOTAL	\$ 6,530
ADP	Payroll Processing		967					
Paycor	Payroll Processing		12,414					
eHealth Data Solutions	MDS Software		3,180					
Allegiance	Employee Compliance		56					
Prospect Resources	Natural Gas Procurement		650					
First Real Estate Service	Appraisal Service		2,750					
Pinnacle Consulting	Customer Satisfaction Survey		2,222					
See Supplemental Schedule			103,816					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 155,060					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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

0048678

Report Period Beginning:

01/01/09

Ending:

12/31/09

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? No
If YES, give association name and amount. N/A
- (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? 10Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,064 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 141,803
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.