

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>40,489</u>	<u>1,228</u>	<u>6,967</u>	<u>48,684</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>40,489</u>	<u>1,228</u>	<u>6,967</u>	<u>48,684</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.50%

D. How many bed-hold days during this year were paid by the Department? 158 (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 6,849

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	262,304	68,704	21,861	352,869		352,869	6,453	359,322		1
2	Food Purchase		283,436		283,436		283,436	173	283,609		2
3	Housekeeping	209,776	79,214	1,609	290,599		290,599	(3,937)	286,662		3
4	Laundry	64,511	35,100		99,611		99,611	(895)	98,716		4
5	Heat and Other Utilities			216,240	216,240		216,240	1,063	217,303		5
6	Maintenance	139,937		162,921	302,858		302,858	(6,808)	296,050		6
7	Other (specify):*							3,743	3,743		7
8	TOTAL General Services	676,528	466,454	402,631	1,545,613		1,545,613	(208)	1,545,405		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	2,636,852	163,669	38,085	2,838,606		2,838,606	33,454	2,872,060		10
10a	Therapy	147,200			147,200		147,200		147,200		10a
11	Activities	148,465	26,035		174,500		174,500		174,500		11
12	Social Services	166,866	3,243	4,905	175,014		175,014	5,864	180,878		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							10,924	10,924		15
16	TOTAL Health Care and Programs	3,099,383	192,947	63,990	3,356,320		3,356,320	50,242	3,406,562		16
	C. General Administration										
17	Administrative	145,361			145,361		145,361	46,386	191,747		17
18	Directors Fees										18
19	Professional Services			623,361	623,361	(3,750)	619,611	(448,814)	170,797		19
20	Dues, Fees, Subscriptions & Promotions			61,932	61,932		61,932	(7,427)	54,505		20
21	Clerical & General Office Expenses	89,940	36,495	243,286	369,721		369,721	(38,599)	331,122		21
22	Employee Benefits & Payroll Taxes			769,817	769,817		769,817	(23,064)	746,753		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,761	2,761		2,761	1,950	4,711		24
25	Other Admin. Staff Transportation			1,338	1,338		1,338	425	1,763		25
26	Insurance-Prop.Liab.Malpractice			166,088	166,088		166,088	945	167,033		26
27	Other (specify):*							27,098	27,098		27
28	TOTAL General Administration	235,301	36,495	1,868,583	2,140,379	(3,750)	2,136,629	(441,100)	1,695,529		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,011,212	695,896	2,335,204	7,042,312	(3,750)	7,038,562	(391,066)	6,647,496		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			27,112	27,112		27,112	108,710	135,822			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119,557	119,557		119,557	180,309	299,866			32
33	Real Estate Taxes			370,774	370,774	3,750	374,524	1,574	376,098			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles			1,549	1,549		1,549	3,299	4,848			35
36	Other (specify):*											36
37	TOTAL Ownership			878,992	878,992	3,750	882,742	(66,108)	816,634			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		413,340	732,945	1,146,285		1,146,285	(165,772)	980,513			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			333,187	333,187		333,187		333,187			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		413,340	1,066,132	1,479,472		1,479,472	(165,772)	1,313,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,011,212	1,109,236	4,280,328	9,400,776		9,400,776	(622,946)	8,777,830			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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,363)	30		9
10	Interest and Other Investment Income	(22,462)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(71)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,821)	21		18
19	Entertainment				19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(145,434)	21		24
25	Fund Raising, Advertising and Promotional	(9,098)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(272,739)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (470,239)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(152,706)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (152,706)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (622,946)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

South Suburban Rehabilitation Center, Llc

ID# 0048678

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Jury Duty	\$ (34)	10	1
2	Theft Loss	(80)	21	2
3	Mics. Income - Collection Records	(70)	21	3
4	Annual Report	(250)	20	4
5	Collection Expense	(2,655)	21	5
6	Bldg. Co. - Amortization	(153,333)	31	6
7	Bldg. Co. - Bank Charge	(312)	21	7
8	Bldg. Co. - Filling Fee	(250)	20	8
9	Capitalized R&M	(16,184)	06	9
10	Non-Allowable PY Legal	(96,768)	19	10
11	Non-Allowable PY Professional Fees	(318)	19	11
12	Professional Fees Refund	(1,500)	19	12
13	PY Expense	(984)	21	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
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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	(272,739)		49

South Suburban Rehabilitation Center, Llc

ID# 0048678

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
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69			20
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77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
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97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Suburban Rehabilitation Center, Llc# 0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

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			254		7,091		(890)	(2)				6,453	1
2	Food Purchase	(71)		244									173	2
3	Housekeeping			514		92			(4,543)				(3,937)	3
4	Laundry								(895)				(895)	4
5	Heat and Other Utilities			901		162							1,063	5
6	Maintenance	(16,184)		2,588	6,850	33			(95)				(6,808)	6
7	Other (specify):*				2,549	1,194							3,743	7
8	TOTAL General Services	(16,255)		4,501	9,399	8,572		(890)	(5,535)				(208)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)				39,567			(6,078)				33,454	10
10a	Therapy													10a
11	Activities													11
12	Social Services					5,864							5,864	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,648	3,276						10,924	15
16	TOTAL Health Care and Programs	(34)				53,079	3,276		(6,078)				50,242	16
	C. General Administration													
17	Administrative			2,704	9,206	34,476							46,386	17
18	Directors Fees													18
19	Professional Services	(98,587)		(274,750)		(75,477)							(448,814)	19
20	Fees, Subscriptions & Promotions	(10,848)	250	3,027		144							(7,427)	20
21	Clerical & General Office Expenses	(151,356)	312	11,211	94,102	7,132							(38,599)	21
22	Employee Benefits & Payroll Taxes				(19,756)		(3,276)		(32)				(23,064)	22
23	Inservice Training & Education													23
24	Travel and Seminar			167		1,783							1,950	24
25	Other Admin. Staff Transportation			425									425	25
26	Insurance-Prop.Liab.Malpractice			805		140							945	26
27	Other (specify):*				20,537	6,561							27,098	27
28	TOTAL General Administration	(260,791)	562	(256,411)	104,089	(25,241)	(3,276)		(32)				(441,100)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(277,081)	562	(251,910)	113,488	36,410		(890)	(11,645)				(391,066)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Suburban Rehabilitation Center, Llc# 0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(17,363)	116,218	8,703		1,333			(181)				108,710	30
31	Amortization of Pre-Op. & Org.	(153,333)	153,333											31
32	Interest	(22,462)	194,946	7,402		423							180,309	32
33	Real Estate Taxes			1,334		240							1,574	33
34	Rent-Facility & Grounds		(360,000)										(360,000)	34
35	Rent-Equipment & Vehicles			3,299									3,299	35
36	Other (specify):*													36
37	TOTAL Ownership	(193,158)	104,497	20,738		1,996			(181)				(66,108)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(7,687)	(5,973)		(151,908)	(203)	(165,772)	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							(7,687)	(5,973)		(151,908)	(203)	(165,772)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(470,239)	105,059	(231,172)	113,488	38,406		(8,577)	(17,799)		(151,908)	(203)	(622,946)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
1	V	34 Rent Income	\$ 360,000	Homewood Mercy Property, LLC.	100.00%	\$	(360,000)	1
2	V	32 Interest	75,880	Homewood Mercy Property, LLC.	100.00%	270,826	194,946	2
3	V	33 Real Estate Tax Expense	370,774	Homewood Mercy Property, LLC.	100.00%	370,774		3
4	V	31 Amortization - Goodwill		Homewood Mercy Property, LLC.	100.00%	153,333	153,333	4
5	V	21 Bank Charge		Homewood Mercy Property, LLC.	100.00%	312	312	5
6	V	30 Depreciation Expense		Homewood Mercy Property, LLC.	100.00%	116,218	116,218	6
7	V	20 Filing Fee		Homewood Mercy Property, LLC.	100.00%	250	250	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 806,654			\$ 911,713	\$ * 105,059	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%	\$ 254	\$	254	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	244		244	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	514		514	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	901		901	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	2,588		2,588	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,704		2,704	20
21	V	19 Professional Fees	281,206	Extended Care Consulting, LLC	100.00%	5,054		(274,750)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,027		3,027	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	11,211		11,211	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	167		167	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	425		425	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	805		805	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	8,703		8,703	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	7,402		7,402	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,334		1,334	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%				30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	3,299		3,299	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 281,206			\$ 48,632	\$ *	(231,172)	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%	6,850	\$	6,850	15
16	V	06 Maintenance (Direct)	10,158	Extended Care Consulting, LLC	100.00%	10,158			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,228		1,228	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,321		1,321	18
19	V	12 Admission (Direct)		Extended Care Consulting, LLC	100.00%				19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%				20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,206		9,206	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	94,102		94,102	22
23	V	21 Office and Clerical (Direct)	27,579	Extended Care Consulting, LLC	100.00%	27,579			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	17,775		17,775	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,762		2,762	25
26	V	22 Employee Benefits	19,756	Extended Care Consulting, LLC	100.00%			(19,756)	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		\$ 57,493			\$ 170,981	\$ *	113,488	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%	\$ 92	\$	92	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	162		162	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	33		33	17
18	V	19 Professional Fees	93,264	Extended Care Clinical, LLC	100.00%	17,787		(75,477)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	144		144	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	2,629		2,629	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,783		1,783	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	140		140	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,333		1,333	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	423		423	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	240		240	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	7,091		7,091	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,194		1,194	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	39,567		39,567	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%				29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	5,864		5,864	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,648		7,648	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	34,476		34,476	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	4,503		4,503	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,561		6,561	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 93,264			\$ 131,670	\$ *	38,406	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	01 Dietary Salary	\$	Extended Care Clinical, LLC	100.00%	\$	\$	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10 Nursing / Medical Record Salary	27,892	Extended Care Clinical, LLC	100.00%	27,892		17
18	V	12 Social Service / Admission Salary	4,673	Extended Care Clinical, LLC	100.00%	4,673		18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,276	3,276	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22 Employee Benefits	3,276	Extended Care Clinical, LLC	100.00%		(3,276)	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		\$ 35,841			\$ 35,841	\$ *	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 Supplies, Supplements	\$ 1,857	Care Centers Health Systems, Inc.	100.00%	\$ 967	\$ (890)
16	V	2 Food		Care Centers Health Systems, Inc.	100.00%		
17	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
18	V	39 Ancillary Expense	16,041	Care Centers Health Systems, Inc.	100.00%	8,353	(7,687)
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		\$ 17,897			\$ 9,320	\$ * (8,577)

* 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	\$ 36	Xcel Supply, LLC	100.00%	\$ 33	\$ (2)
16	V	3 Housekeeping	74,938	Xcel Supply, LLC	100.00%	70,395	(4,543)
17	V	4 Laundry	14,767	Xcel Supply, LLC	100.00%	13,871	(895)
18	V	6 Repairs & Maintenance	1,559	Xcel Supply, LLC	100.00%	1,464	(95)
19	V	10 Nursing	100,261	Xcel Supply, LLC	100.00%	94,183	(6,078)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
22	V	22 Employee Benefits	534	Xcel Supply, LLC	100.00%	501	(32)
23	V	30 Fixed Assets-Depreciation	2,983	Xcel Supply, LLC	100.00%	2,802	(181)
24	V	39 Ancillary	98,528	Xcel Supply, LLC	100.00%	92,555	(5,973)
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		\$ 293,604			\$ 275,805	\$ * (17,799)

* 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%	\$ 89,042	\$ 89,042	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	89,042	CCS Employee Benefits Group	100.00%		(89,042)	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		\$ 89,042			\$ 89,042	\$ *	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	\$ 715,153	TriCare Rehab	100.00%	\$ 563,245	\$ (151,908)
16	V						
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		\$ 715,153			\$ 563,245	\$ * (151,908)

* 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	6 R&M - Equipment	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$	15	
16	V	10 Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16	
17	V	39 Ancillary Expense	22,688	Reliable Medical of the Midwest, LLC	100.00%	22,485	(203)	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		\$ 22,688			\$ 22,485	\$ *	(203)	39

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

Facility Name & ID Number

South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	HOMEWOOD MERCY PROPERT		BUILDING CO.	1
2	GALE ROTHNER	49.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKK	2
3			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC CHICAGO		EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE, LTD.	INDIAN HEAD	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPP	4
5			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7			DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			GRASMERE PLACE, LLC	CHICAGO	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			GOLDEN PLAINES	HUTCHINSON, OK	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	9
10			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				10
11			HOMESTEAD NURSING & REAHB	LINCOLN, NE				11
12			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				12
13			LAKWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				13
14			LANCASTER MANOR	LINCOLN, NE				14
15			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				15
16			MCKINLEY HEALTH CARE CENTER	CANTON, OH				16
17			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				17
18			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				18
19			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				19
20			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				20
21			RAINBOW BEACH QOC, L.L.C.	CHICAGO				21
22			SEBOS NURSING & REHAB	HOBART, IN				22
23			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				23
24			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				24
25			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				25
26			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				26
27			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				27
28			WHEATON CARE CENTER, LLC	WHEATON				28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	G. Matt Silvers	Relative	Administrative	N/A	See Attached	0.93	2.33%	Alloc. Salary	\$ 3,682	17-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.2	5.82%	AI Sal/AI Fees	10,495	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.66	1.65%	Alloc. Salary	1,162	22-7	3
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										7
8	the IL. Dept of HFS										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,339		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, Llc # 0048678 Report Period Beginning: 01/01/11 Ending: 12/31/11

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, Llc

0048678

Report Period Beginning:

01/01/11

Ending: 12/31/11

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	31	\$ 6,942	\$	48,684	\$ 254	1
2	02	Food	Patient Days	31	6,677		48,684	244	2
3	03	Housekeeping	Patient Days	31	14,059		48,684	514	3
4	05	Utilities	Patient Days	31	24,674		48,684	901	4
5	06	Maintenance	Patient Days	31	70,833		48,684	2,588	5
6	17	Administrative	Patient Days	31	74,000		48,684	2,704	6
7	19	Professional Fees	Patient Days	31	138,332		48,684	5,054	7
8	20	Dues and Subscriptions	Patient Days	31	82,842		48,684	3,027	8
9	21	Office and Clerical	Patient Days	31	306,863		48,684	11,211	9
10	24	Seminar and Travel	Patient Days	31	4,580		48,684	167	10
11	25	Other Staff Admin. Trans.	Patient Days	31	11,637		48,684	425	11
12	26	Insurance	Patient Days	31	22,043		48,684	805	12
13	30	Depreciation	Patient Days	31	238,204		48,684	8,703	13
14	32	Interest	Patient Days	31	202,602		48,684	7,402	14
15	33	Real Estate Taxes	Patient Days	31	36,524		48,684	1,334	15
16	34	Rent - Building	Patient Days	31			48,684		16
17	35	Rent - Equipment & Auto	Patient Days	31	90,286		48,684	3,299	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,331,096	\$		\$ 48,632	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	06	Maintenance (Pooled)	Patient Days	31	187,474	187,474	48,684	6,850	1
2	06	Maintenance (Direct)	Direct	31	122,603	122,603		10,158	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	31	33,619		48,684	1,228	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	31	16,441			1,321	4
5	12	Admission (Direct)	Direct	31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct	31					6
7	17	Administrative (Pooled)	Patient Days	31	251,959	251,959	48,684	9,206	7
8	21	Office and Clerical (Pooled)	Patient Days	31	2,575,611	2,575,611	48,684	94,102	8
9	21	Office and Clerical (Direct)	Direct	31	545,076	545,076		27,579	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	31	486,522		48,684	17,775	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	31	78,893			2,762	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				\$ 4,298,198	\$ 3,682,723		\$ 170,981	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending: 12/31/11

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

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

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	03	Housekeeping	Patient Days	817,528	19	\$ 1,549	\$ 48,684	\$ 92	1
2	05	Utilities	Patient Days	817,528	19	2,718	48,684	162	2
3	06	Maintenance	Patient Days	817,528	19	557	48,684	33	3
4	19	Professional Fees	Patient Days	817,528	19	298,695	48,684	17,787	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426	48,684	144	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146	48,684	2,629	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934	48,684	1,783	7
8	26	Insurance	Patient Days	817,528	19	2,346	48,684	140	8
9	30	Depreciation	Patient Days	817,528	19	22,389	48,684	1,333	9
10	32	Interest	Patient Days	817,528	19	7,100	48,684	423	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024	48,684	240	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	48,684	7,091	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044	48,684	1,194	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	48,684	39,567	14
15	10a	Rehab Salary	Patient Days	817,528	19		48,684		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	48,684	5,864	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421	48,684	7,648	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	48,684	34,476	18
19	21	Office Salary	Patient Days	817,528	19	75,625	48,684	4,503	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184	48,684	6,561	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,211,073	\$ 1,536,540	\$ 131,670	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending: 12/31/11

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	01	Dietary Salary	Direct Allocation		\$	\$		\$	1
2	07	Emp. Ben. - General	Direct Allocation						2
3	10	Nursing / Medical Record Salary	Direct Allocation		344,209	344,209		27,892	3
4	12	Social Service / Admission Salary	Direct Allocation		174,668	174,668		4,673	4
5	15	Emp. Ben. - Healthcare	Direct Allocation		61,656			3,276	5
6	17	Administration Salary	Direct Allocation						6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation						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				\$ 580,533	\$ 518,877		\$ 35,841	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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	1	Dietary Supplies, Supplements	Direct Allocation		\$	\$		\$ 967	1
2	2	Food	Direct Allocation						2
3	10	Nursing Supplies	Direct Allocation						3
4	39	Ancillary Expense	Direct Allocation					8,353	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				\$	\$		\$ 9,320	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending: 12/31/11

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		\$	\$		\$ 33	1
2	3	Housekeeping	Direct Allocation					70,395	2
3	4	Laundry	Direct Allocation					13,871	3
4	6	Repairs & Maintenance	Direct Allocation					1,464	4
5	10	Nursing	Direct Allocation					94,183	5
6	11	Activities	Direct Allocation						6
7	21	Office And Clerical	Direct Allocation						7
8	22	Employee Benefits	Direct Allocation					501	8
9	30	Fixed Assets-Depreciation	Direct Allocation					2,802	9
10	39	Ancillary	Direct Allocation					92,555	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				\$	\$		\$ 275,805	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 89,042	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				\$	\$		\$ 89,042	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc # 0048678 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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	39	Therapy	Direct Allocation		\$	\$		\$ 563,245	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				\$	\$		\$ 563,245	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue
 City / State / Zip Code Des Plaines, Illinois 60018-5909
 Phone Number (847) 566-0800
 Fax Number (

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	6	R&M - Equipment	Direct Allocation		\$	\$		\$	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					22,485	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				\$	\$		\$ 22,485	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	Reporting Period Interest Expense									
												Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
												YES	NO				Original	Balance		
	A. Directly Facility Related																			
	Long-Term																			
1	Bank Leumi		X								\$ 46,276	1								
2	National City / Ridgeland		X	Mortgage Loan					2,464,021			122,092	2							
3													3							
4													4							
5	See Supplemental Schedule												5							
	Working Capital																			
6	HFG											148,734	6							
7	Lake Forest		X									55,233	7							
8	See Supplemental Schedule											25,873	8							
9	TOTAL Facility Related					\$	\$ 2,464,021				\$	398,208	9							
	B. Non-Facility Related*																			
10	Interest Income		X									(22,462)	10							
11	Interest Income - Bldg Co.		X									(75,880)	11							
12													12							
13	See Supplemental Schedule												13							
14	TOTAL Non-Facility Related					\$	\$				\$	(98,342)	14							
15	TOTALS (line 9+line14)					\$	\$ 2,464,021				\$	299,866	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, Llc

0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	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	Cole Taylor Bank		X				\$	\$			\$	17,830	8						
9	Union Expense		X									155	9						
10	DIAWA		X									63	10						
11	Alloc from Ext Care Consult		X									7,402	11						
12	Alloc from Ext Care Clinical		X									423	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 bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	259,957		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.)		\$	309,248		2
3. Under or (over) accrual (line 2 minus line 1).		\$	49,291		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	503,057		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.)		\$	3,750		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 \$ _____ For _____ 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.		\$	556,098		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	445,015			8
	2007	172,220			9
	2008	233,674			10
	2009	247,578			11
	2010	307,674			12
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2010	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16
2011 Accrual: 2010 R/E Tax \$307,674 x 1.05 = \$323,057					
Alloc from Extended Care Consulting, LLC \$1,334					
Alloc from Extended Care Clinical \$240					

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Suburban Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048678

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2007</u>	<u>\$ 600,000</u>	<u>1</u>
2	<u>Allocated from Extended Care Constl. & Clinical</u>			<u>14,247</u>	<u>2</u>
3	TOTALS			\$ 614,247	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	259			1976	\$ 3,196,000	\$ 116,218	35	\$ 91,314	\$ (24,904)	\$ 456,570	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2007		32,306		20	2,956	2,956	12,941	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 and Improvement Costs-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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68		57,693	3,923		3,923		31,283
69			26,931			(26,931)	
70		\$ 3,285,999	\$ 147,072		\$ 98,194	\$ (48,878)	\$ 500,795

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, Llc

0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 3,285,999	\$ 147,072		\$ 98,194	\$ (48,878)	\$ 500,795	1
2	Backflow Preventer Installation	2008	5,365		20	268	268	1,073	2
3	Install Floor In Walk-In Freezer	2008	3,600		20	180	180	720	3
4	Exterior Street Sign - Double Faced	2008	7,716		20	514	514	2,058	4
5	Exterior Street Sign	2008	8,941		20	596	596	2,384	5
6	Security System	2008	3,380		20	169	169	606	6
7	New Laundry Room 2Nd Floor	2008	2,530		20	127	127	432	7
8	Install New Metal Doors With Frame	2008	3,750		20	188	188	594	8
9	Roofing	2008	2,500		20	125	125	500	9
10	Roofing	2008	900		20	45	45	180	10
11	Plumbing	2008	2,850		20	143	143	570	11
12	Smoke Dampers	2009	26,600		20	1,330	1,330	3,879	12
13	Security System For Front Door	2009	2,644		20	529	529	1,102	13
14	Sidewalk	2010	3,565		20	238	238	396	14
15	4 Locks	2010	3,250		20	650	650	1,029	15
16	Walk In Freezer	2010	5,100		20	1,020	1,020	1,530	16
17	Shower Renovation	2010	14,701		20	735	735	919	17
18	Ceramic Tile In Kitchen	2010	5,550		20	278	278	324	18
19	Roof Repair - East & West Side	2010	4,200		20	210	210	420	19
20	Install New Sec System	2011	4,748		20	870	870	870	20
21	Painting	2011	4,007		20	3,339	3,339	3,339	21
22	Bracelets & Alarm W/ 2 Keypads	2011	7,617		20	1,269	1,269	1,269	22
23	Painting	2011	12,177		20	9,133	9,133	9,133	23
24	Paint, Molding, Outlet, Switches, Walls	2011	2,936		20	110	110	110	24
25	Install 5 Condensing Units	2011	61,900		20	2,321	2,321	2,321	25
26	Imperial Water Booster	2011	2,606		20	391	391	391	26
27	Steel Door & Dead Bolt Lock	2011	2,664		20	89	89	89	27
28	Shower, Walls, Tiles, Floor & Lights	2011	6,500		20	135	135	135	28
29	Pool, Demo, Concrete, Floor & Vinyl Base	2011	14,200		20	237	237	237	29
30	New Heat Exchange	2011	2,583		20	129	129	129	30
31	Wallpaper Project	2011	15,248		20	762	762	762	31
32	Wander System	2011	3,274		20	164	164	164	32
33	Privacy Curtains	2011	4,429		20	221	221	221	33
34	TOTAL (lines 1 thru 33)		\$ 3,538,030	\$ 147,072		\$ 124,709	\$ (22,363)	\$ 538,681	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,538,030	\$ 147,072		\$ 124,709	\$ (22,363)	\$ 538,681	1
2	Cubicle Curtains	2011	2,983		20	149	149	149	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)		\$ 3,541,012	\$ 147,072		\$ 124,858	\$ (22,214)	\$ 538,831	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 and Improvement Costs-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		\$ 3,541,012	\$ 147,072		\$ 124,858	\$ (22,214)	\$ 538,831	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		\$ 3,541,012	\$ 147,072		\$ 124,858	\$ (22,214)	\$ 538,831	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 and Improvement Costs-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		\$ 3,541,012	\$ 147,072		\$ 124,858	\$ (22,214)	\$ 538,831	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		\$ 3,541,012	\$ 147,072		\$ 124,858	\$ (22,214)	\$ 538,831	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

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

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 and Improvement Costs-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	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	2,989	77	39	77		712	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	16,644	427	39	427		3,965	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2002	13,749	1,257	20	1,257		10,064	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2003	16,203	1,481	20	1,481		11,861	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2005	805	86	20	86		461	12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2009	145	7	20	7		22	13
14									14
15									15
16									16
17	Allocated from Extended Care Consulting, LLC	2007	168	8	20	8		42	17
18	Allocated from Extended Care Consulting, LLC	2009	100	5	20	5		15	18
19	Allocated from Extended Care Consulting, LLC	2010	986	49	20	49		99	19
20	Allocated from Extended Care Consulting, LLC	2011	355	18	20	18		18	20
21									21
22									22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	2,469	226	20	226		1,807	23
24	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	2,909	266	20	266		2,130	24
25	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	145	15	20	15		83	25
26	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	26	1	20	1		4	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 and Improvement Costs-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)		\$ 57,693	\$ 3,923		\$ 3,923	\$	\$ 31,283	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 68,029	\$ 5,253	\$ 9,212	\$ 3,959	10	\$ 47,754	71
72	Current Year Purchases	9,034	12	903	891	10	903	72
73	Fully Depreciated Assets	2,175,558				10	2,175,558	73
74								74
75	TOTALS	\$ 2,252,621	\$ 5,265	\$ 10,116	\$ 4,851		\$ 2,224,215	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. From EC Clinical	2009	\$ 3,329	\$ 666	\$ 666		5	\$ 2,219	76
77		Alloc. From ECC	2009	11,748	183	183		5	11,565	77
78										78
79										79
80	TOTALS			\$ 15,077	\$ 849	\$ 849			\$ 13,784	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)	\$ 6,422,957	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 153,186	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,823	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,363)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,776,830	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,848 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. _____/2012 \$ _____

13. _____/2013 \$ _____

14. _____/2014 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 297,266	\$		\$ 297,266	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			118,339			118,339	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			299,548			299,548	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				248,391		248,391	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>					17,792	164,949		182,741	13
14	TOTAL			\$		\$ 732,945	\$ 413,340		\$ 1,146,285	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc# 0048678Report Period Beginning: 01/01/11Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 11,149	\$ 57,995	1
2	Cash-Patient Deposits	42,319	42,319	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,099,601	2,099,601	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	298,964	298,964	6
7	Other Prepaid Expenses	7,731	7,731	7
8	Accounts Receivable (owners or related parties)	(1,201)	(1,201)	8
9	Other(specify): <u>See Attached Schedule</u>	1,176,994	3,336,031	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,635,557	\$ 5,841,440	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		3,196,000	14
15	Leasehold Improvements, at Historical Cost	207,787	207,787	15
16	Equipment, at Historical Cost	85,360	2,157,360	16
17	Accumulated Depreciation (book methods)	(59,297)	(3,288,632)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		1,215,192	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 233,850	\$ 4,087,707	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,869,407	\$ 9,929,147	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 4,841,853	\$ 4,841,853	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,676	38,676	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,584	157,584	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,277	8,277	31
32	Accrued Real Estate Taxes(Sch.IX-B)	323,057	503,057	32
33	Accrued Interest Payable	191,381	203,329	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	448,873	6,965,873	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,009,701	\$ 12,718,649	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,464,021	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>		1,850,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,314,021	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,009,701	\$ 17,032,670	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,140,294)	\$ (7,103,523)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,869,407	\$ 9,929,147	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,093,390)	1
2	Restatements (describe):		2
3	Rounding Error	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,093,386)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	953,092	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)	\$ 953,092	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)	\$ (2,140,294)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Suburban Rehabilitation Center, Llc

0048678

Report Period Beginning: 01/01/11

Ending: 12/31/11

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	\$ 10,098,126	1
2	Discounts and Allowances for all Levels	(2,325,259)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,772,867	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,152,714	6
7	Oxygen	20,476	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,173,190	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	287,557	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,771	19
20	Radiology and X-Ray	3,538	20
21	Other Medical Services	54,006	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 354,872	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22,462	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,462	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	30,477	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,477	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,353,868	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,545,613	31
32	Health Care	3,356,320	32
33	General Administration	2,140,379	33
B. Capital Expense			
34	Ownership	878,992	34
C. Ancillary Expense			
35	Special Cost Centers	1,146,285	35
36	Provider Participation Fee	333,187	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,400,776	40
41	Income before Income Taxes (line 30 minus line 40)**	953,092	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 953,092	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, Llc**

0048678

Report Period Beginning:

01/01/11

Ending:

12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,518	1,709	\$ 77,308	\$ 45.24	1
2	Assistant Director of Nursing	1,812	2,011	70,734	35.17	2
3	Registered Nurses	13,238	14,836	432,398	29.15	3
4	Licensed Practical Nurses	40,259	42,868	1,091,172	25.45	4
5	CNAs & Orderlies	86,055	93,531	901,987	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,890	11,123	147,200	13.23	8
9	Activity Director	2,062	2,134	31,513	14.77	9
10	Activity Assistants	12,020	13,332	116,952	8.77	10
11	Social Service Workers	6,720	7,428	166,866	22.46	11
12	Dietician	923	964	12,086	12.53	12
13	Food Service Supervisor	1,905	2,128	40,651	19.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,519	5,188	66,773	12.87	15
16	Dishwashers	13,424	14,839	142,794	9.62	16
17	Maintenance Workers	7,384	8,175	139,937	17.12	17
18	Housekeepers	17,438	19,520	209,776	10.75	18
19	Laundry	5,268	6,041	64,511	10.68	19
20	Administrator	1,990	2,244	103,354	46.06	20
21	Assistant Administrator	1,578	1,771	42,007	23.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,658	6,281	89,940	14.32	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	2,087	2,293	30,934	13.49	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,132	2,298	32,319	14.06	33
34	TOTAL (lines 1 - 33)	237,879	260,715	\$ 4,011,212 *	\$ 15.39	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	547	\$ 21,861	01-03	35
36	Medical Director	Monthly	21,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,860	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	4	232	12-03	45
46	Other(specify)				46
47					47
48	<u>See Attached</u>		32,565		48
49	TOTAL (lines 35 - 48)	551	\$ 84,518		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	27	\$ 1,333	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	27	\$ 1,333		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Marc Halpert	Administrator	0%	\$ 103,354	Workers' Compensation Insurance	\$ 196,887	IDPH License Fee	\$	
Stephanie K. Mohr	Asst Admin	0%	42,007	Unemployment Compensation Insurance	185,718	Advertising: Employee Recruitment	20,941	
				FICA Taxes	281,329	Health Care Worker Background Check		
				Employee Health Insurance	49,303	(Indicate # of checks performed <u>361</u>)	5,354	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscription	22,862	
				Employee Physicals	3,784	Licenses & Fees	2,177	
				Pension Expenses	15,105	Alloc from Ext Care Consult.	3,027	
				Other Employee Welfare	14,627	Alloc from Ext Care Clinical	144	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 145,362					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg&Rothblatt	Accounting		\$ 38,950			\$	Out-of-State Travel	\$
Personnel Planners	Unemployment Consult.		3,286					
Ext. Care Consulting	Home Office Expenses		279,804					
Ext. Care Clinical	Home Office Expenses		93,264				In-State Travel	
AIS Assessment	MDS Training		2,035					
Paycor	Payroll Processing		15,698					
eHealth Data Solutions	MDS Software		2,385					
DAIWA	LOC		26,101				Seminar Expense	1,822
Blymass	Tax Credits		4,331				Inservice Expense	939
Extended Care Consult. LLC	Other Professional Fees		1,402				Alloc from Ext Care Consulting	167
Pinnacle Consulting	Customer Satisfaction Survey		4,353					1,783
See Supplemental Schedule			151,751				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 623,359				line 24, col. 8)	\$ 4,711

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$19,813.5
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 43,374 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 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. \$ 333,187
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.

SEE ACCOUNTANTS' COMPILATION REPORT