FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0047340

Facility Name: Montebello Healthcare Center

Address: 1599 Keokuk Street (Number) Hamilton (City) 62341 (Zip Code)

County: Hancock

Telephone Number: 217-847-3931 **Fax #** 217-847-2067

HFS ID Number:

Date of Initial License for Current Owners: 10/06/2005

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Martha McDaniel **Telephone Number:** 832-467-6317
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Chris Stenger

(Title) Vice President of Planning and Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,735	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	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,011	3,213	4,336	20,560	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,011	3,213	4,336	20,560	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.52%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 139 and days of care provided 3,174

Medicare Intermediary Trailblazer

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	102,485	10,199	7,819	120,503		120,503		120,503			1
2	Food Purchase		100,553		100,553		100,553	(78)	100,475			2
3	Housekeeping	67,871	10,335	3,933	82,139		82,139		82,139			3
4	Laundry	24,964	7,568		32,532		32,532		32,532			4
5	Heat and Other Utilities			105,460	105,460		105,460	(3,272)	102,188			5
6	Maintenance	32,177	68,149	8,087	108,413		108,413	5,869	114,282			6
7	Other (specify):*			8,891	8,891		8,891		8,891			7
8	TOTAL General Services	227,497	196,804	134,190	558,491		558,491	2,519	561,010			8
	B. Health Care and Programs											
9	Medical Director			7,403	7,403		7,403		7,403			9
10	Nursing and Medical Records	911,626	73,889	9,227	994,742		994,742		994,742			10
10a	Therapy		18,110	444,201	462,311		462,311		462,311			10a
11	Activities	33,878	2,703	3,584	40,165		40,165		40,165			11
12	Social Services	31,658		2,845	34,503		34,503		34,503			12
13	CNA Training											13
14	Program Transportation	26,815	3,466	1,373	31,654		31,654		31,654			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,003,977	98,168	468,633	1,570,778		1,570,778		1,570,778			16
	C. General Administration											
17	Administrative	88,538			88,538		88,538		88,538			17
18	Directors Fees			500	500		500		500			18
19	Professional Services			1,756	1,756		1,756		1,756			19
20	Dues, Fees, Subscriptions & Promotions			28,519	28,519		28,519	555	29,074			20
21	Clerical & General Office Expenses	104,360	14,920	240,373	359,653		359,653	(73,983)	285,670			21
22	Employee Benefits & Payroll Taxes			160,719	160,719		160,719	7,064	167,783			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,313	25,313		25,313	26,011	51,324			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			108,955	108,955		108,955	(73,557)	35,398			26
27	Other (specify):*											27
28	TOTAL General Administration	192,898	14,920	566,135	773,953		773,953	(113,910)	660,043			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,424,372	309,892	1,168,958	2,903,222		2,903,222	(111,391)	2,791,831			29

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

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

Facility Name & ID Number Montebello Healthcare Center #0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,465	41,465		41,465	(6,341)	35,124			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(50)	(50)		(50)	5,096	5,046			32
33	Real Estate Taxes			64,150	64,150		64,150	407	64,557			33
34	Rent-Facility & Grounds			17,665	17,665		17,665		17,665			34
35	Rent-Equipment & Vehicles			123	123		123	6,720	6,843			35
36	Other (specify):*							7,719	7,719			36
37	TOTAL Ownership			123,353	123,353		123,353	13,601	136,954			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,565	14,739	65,304		65,304	6,045	71,349			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,102	76,102		76,102		76,102			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		50,565	90,841	141,406		141,406	6,045	147,451			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,424,372	360,457	1,383,152	3,167,981		3,167,981	(91,745)	3,076,236			45

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,272)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,341)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(78)	2		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	(6,500)	21		18
19	Entertainment				19
20	Contributions	210	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,923)	21		24
25	Fund Raising, Advertising and Promotional	(3,236)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(416)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,556)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	203,876		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 203,876		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 150,320		37

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

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

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

Montebello Healthcare Center

ID# 0047340

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services	$ (163,779)	21	1
2	Professional Liability Insurance	(78,587)	26	2
3	Real Estate Tax Accrual Adj	302	33	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(242,064)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center # 0047340 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(78)	0	0	0	0	0	0	0	0	0	0	(78)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,272)	0	0	0	0	0	0	0	0	0	0	(3,272)	5
6	Maintenance	0	5,869	0	0	0	0	0	0	0	0	0	5,869	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,350)	5,869	0	0	0	0	0	0	0	0	0	2,519	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(416)	971	0	0	0	0	0	0	0	0	0	555	20
21	Clerical & General Office Expenses	(207,228)	133,245	0	0	0	0	0	0	0	0	0	(73,983)	21
22	Employee Benefits & Payroll Taxes	0	7,064	0	0	0	0	0	0	0	0	0	7,064	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	26,011	0	0	0	0	0	0	0	0	0	26,011	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(78,587)	5,030	0	0	0	0	0	0	0	0	0	(73,557)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(286,231)	172,321	0	0	0	0	0	0	0	0	0	(113,910)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(289,581)	178,190	0	0	0	0	0	0	0	0	0	(111,391)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montebello Healthcare Center # 0047340 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(6,341)	0	0	0	0	0	0	0	0	0	0	(6,341)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	5,096	0	0	0	0	0	0	0	0	0	5,096	32
33	Real Estate Taxes	302	105	0	0	0	0	0	0	0	0	0	407	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	6,720	0	0	0	0	0	0	0	0	0	6,720	35
36	Other (specify):*	0	7,719	0	0	0	0	0	0	0	0	0	7,719	36
37	**TOTAL Ownership**	(6,039)	19,640	0	0	0	0	0	0	0	0	0	13,601	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	6,045	0	0	0	0	0	0	0	0	0	6,045	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	6,045	0	0	0	0	0	0	0	0	0	6,045	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(295,620)	203,875	0	0	0	0	0	0	0	0	0	(91,745)	45

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	Montebello Health Care Center	Hamilton			
		Nature Trail Health Care Center	Mount Vernon			
		Odin Health Care Center	Odin			
		Westchester Health Care Center	Westchester			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	SSC Equity Holdings, LLC	100.00%	$	$	1
2	V	6	Repair and Maintenance		SSC Equity Holdings, LLC	100.00%	5,869	5,869	2
3	V	39	Professional Services		SSC Equity Holdings, LLC	100.00%	6,045	6,045	3
4	V	20	Fees, Subscriptions and Promos		SSC Equity Holdings, LLC	100.00%	971	971	4
5	V	10	Nursing & Med Records		SSC Equity Holdings, LLC	100.00%			5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings, LLC	100.00%	133,245	133,245	6
7	V	24	Travel & Seminar		SSC Equity Holdings, LLC	100.00%	26,011	26,011	7
8	V	26	Insurance		SSC Equity Holdings, LLC	100.00%	5,030	5,030	8
9	V	36	Depreciation		SSC Equity Holdings, LLC	100.00%	7,719	7,719	9
10	V	33	Taxes - Property		SSC Equity Holdings, LLC	100.00%	105	105	10
11	V	35	Rental & Lease		SSC Equity Holdings, LLC	100.00%	6,720	6,720	11
12	V	32	Interest Income/Expense		SSC Equity Holdings, LLC	100.00%	5,096	5,096	12
13	V	22	Payroll Taxes		SSC Equity Holdings, LLC	100.00%	7,064	7,064	13
14	Total			$			$ 203,875	$ * 203,875	14

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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								TOTAL	$		13

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

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SSC Equity Holdings LLC
Street Address: 5300 W Sam Houston Parkway N Ste 100
City / State / Zip Code: Houston, TX 77041
Phone Number: (832-467-6000
Fax Number: (832-467-6983

	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	5	Utilities				$	$		$	1
2	6	Repair and Maintenance							5,869	2
3	39	Professional Services							6,045	3
4	20	Fees, Subscriptions a& Promos							971	4
5	10	Nursing & Medical Records							0	5
6	21	Clerical & Gen Office Exp							133,245	6
7	24	Travel & Seminar							26,011	7
8	26	Insurance							5,030	8
9	36	Depreciation							7,719	9
10	33	Taxes - Proerty							105	10
11	35	Rental & Lease							6,720	11
12	32	Interest Income/Expense							5,096	12
13	22	Payroll Taxes							7,064	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					$	$		$ 203,875	25

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

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

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 58,629	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.)		$ 61,493	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,864	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 61,693	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.**		$	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.		$ 64,557	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	57,210	8
	2006	60,259	9
	2007	55,825	10
	2008	59,087	11
	2009	61,493	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montebello Healthcare Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0047340

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832-467-6317 FAX #: 832-467-6983

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-999-119	Lot B Sub (Ex 2A SE Corner &	$ 61,493.00	$ 61,493.00
2.		377 X 145 SW COR) NE	$	$
3.		Montebello 5-8 12-29B 11-538	$	$
4.		12-2 9-255-011 Keokuk St	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,493.00	$ 61,493.00

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 X NO

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	6 Ton 230V RTU			2005	27,558	2,756	10	2,756	0	14,698	9
10	Four Heat Run Duct System			2005	1,500	130	11.5	130		691	10
11	Repair Damaged Phone System			2005	1,576	158	10	158		841	11
12	Watermain Repair			2005	8,682	755	11.5	755		3,963	12
13	Retaining Wall - Partial Payment			2005	6,359	553	11.5	553		2,903	13
14	Fire Alarm Control Panel			2005	2,404	240	10	240		1,262	14
15	Construct Walkway Cover			2005	5,022	437	11.5	437		2,293	15
16	Leveled Ground around Stairway			2005	525	46	11.5	46		240	16
17	Fire Alarm System			2005	1,824	182	10	182		958	17
18	Install New Handrails			2005	415	36	11.5	36		189	18
19	Fire Alarm Control Panel			2005	872	87	10	87		458	19
20	Drywall Repairs - Water Break			2005	3,975	345	11.5	345		1,815	20
21	16: Toilet and Shower Floors			2005	10,166	897	11.3	897		4,560	21
22	Front Entry Concrete			2005	7,081	625	11.3	625		3,176	22
23	6: Smoke Detectors			2005	1,480	148	10	148		765	23
24	Relays for Emergency Lights			2005	2,776	245	11.3	245		1,245	24
25											25
26	119 Gallon Electric Water Heater			2006	4,362	436	10	436		2,145	26
27	Use Tax: Water Heater			2006	268	27	10	27		132	27
28	Install Water Heater			2006	659	66	10	66		324	28
29	Install Electrical Water Heater			2006	384	38	10	38		189	29
30	42' Sidewalk - Outside Patio			2006	1,820	179	10.175	179		776	30
31	Sprinkler			2006	2,296	226	10.175	226		979	31
32	Repair Sprinkler System			2006	6,893	689	10	689		2,872	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Deposit - Vinyl Floor	2007	$ 1,928	$ 208	9.25	$ 208	$	$ 712	37
38	Vinyl Flooring	2007	2,153	237	9.08	237		770	38
39	Replace AC Compressor - Laundry	2007	1,663	183	9.08	183		595	39
40	Sprikler System Install	2007	1,744	190	9.16	190		634	40
41	Vinyl Flooring 2 Shower/Bathroom	2007	475	53	9	53		167	41
42									42
43									43
44	Backflow Devices - Sprinkler System	2008	21,646	2,428	9	2,428		7,485	44
45	Generator Water Pump	2008	4,412	514	8.58	514		1,414	45
46	Foundation Upgrade	2008	5,340	628	8.5	628		1,675	46
47	Sealed 3 Cracks Below Windows	2008	1,400	162	8.66	162		458	47
48	Water Abatement & Concrete Work	2008	2,670	317	8.41	317		820	48
49	Fire Alarm Maintenance	2008	3,191	387	8.25	387		935	49
50	Genset Wiring	2008	1,903	233	8.25	233		544	50
51	Generatro Remote Annunicator	2008	2,349	288	8.25	288		671	51
52	Dry System Accelerator	2008	8,020	972	8.25	972		2,349	52
53	Water Abatement & Concrete Work	2008	2,670	324	8.25	324		782	53
54									54
55									55
56	Wanderguard Monitor	2009	880	120	7.3	120		180	56
57	Concrete Sidewalk	2009	3,190	450	7.08	450		563	57
58	Anti Scald Mixing Valve	2009	1,074	148	7.25	148		210	58
59									59
60	Basement Door Locks	2010	2,263	354		354		354	60
61	Fire Alarm/Air Handler Connection	2010	5,363	1,369		1,369		1,369	61
62	Wanderguard System Credit	2010	(880)	(119)		(119)		(119)	62
63	Recepticles in 20 Rooms	2010	6,800	850		850		850	63
64	Intumescent Firestop	2010	18,880	2,151		2,151		2,151	64
65	5 Ton Central Air Conditioner	2010	4,580	362		362		362	65
66	Replaced Roof Membrane	2010	4,800	133		133		133	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 207,409	$ 22,243		$ 22,243	$ 0	$ 73,538	70

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 73,570	$ 10,735	$ 10,735	$	5	$ 40,134	71
72	Current Year Purchases	21,054	2,146	2,146		3	2,146	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 94,624	$ 12,881	$ 12,881	$		$ 42,280	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 302,033	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,124	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,124	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 115,818	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SMV Property Holdings, LLC
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. [X] 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:	1974	139		$ 17,665	12		3
4	Additions							4
5								5
6								6
7	TOTAL		139		$ 17,665 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/2005
Ending 12/31/2016

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/2011	$ 17,665
13.	12/2012	$ 17,665
14.	12/2013	$ 17,665

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	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	10a-3	hrs	$		$ 209,992	$		$ 209,992	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			58,343			58,343	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			175,865			175,865	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				50,565		50,565	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 444,200	$ 50,565		$ 494,765	14

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

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 550	$	1
2	Cash-Patient Deposits	23,580		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	114,796		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	912		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 139,838	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,765		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	207,410		15
16	Equipment, at Historical Cost	99,645		16
17	Accumulated Depreciation (book methods)	(115,814)		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): Leasehold Rights	37,519		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 265,525	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 405,363	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,320	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,667		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,283		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,493		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Miscellaneous	1,569		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 413,332	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	418,242		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 418,242	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 831,574	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (426,211)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 405,363	$	48

***(See instructions.)**

Facility Name & ID Number Montebello Healthcare Center **#** 0047340 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (607,103)	1
2	Restatements (describe):	63,116	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (543,987)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	117,776	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)**	$ 117,776	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)**	$ (426,211)	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,485,316	1
2	Discounts and Allowances for all Levels	(905,441)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,579,875	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	597,052	6
7	Oxygen	4,480	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 601,532	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	112	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,852	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,278	19
20	Radiology and X-Ray		20
21	Other Medical Services	(3,661)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 103,581	23
	D. Non-Operating Revenue		
24	Contributions	210	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 210	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts Vending	559	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 559	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,285,757	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	558,491	31
32	Health Care	1,570,778	32
33	General Administration	773,953	33
	B. Capital Expense		
34	Ownership	123,353	34
	C. Ancillary Expense		
35	Special Cost Centers	65,304	35
36	Provider Participation Fee	76,102	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,167,981	40
41	**Income before Income Taxes (line 30 minus line 40)****	117,776	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 117,776	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,615	1,953	$ 54,539	$ 27.93	1
2	Assistant Director of Nursing	814	846	21,038	24.87	2
3	Registered Nurses	5,887	6,286	157,559	25.07	3
4	Licensed Practical Nurses	12,298	13,310	210,681	15.83	4
5	CNAs & Orderlies	41,247	44,562	467,808	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,955	2,099	22,474	10.71	9
10	Activity Assistants	1,251	1,351	11,405	8.44	10
11	Social Service Workers	1,943	2,133	31,658	14.84	11
12	Dietician					12
13	Food Service Supervisor	1,596	1,891	19,856	10.50	13
14	Head Cook	3,804	4,045	34,316	8.48	14
15	Cook Helpers/Assistants	5,275	5,705	48,314	8.47	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,150	32,177	14.97	17
18	Housekeepers	6,324	6,950	67,871	9.77	18
19	Laundry	2,775	2,988	24,964	8.35	19
20	Administrator	1,789	1,905	88,458	46.43	20
21	Assistant Administrator					21
22	Other Administrative	3,268	3,540	81,648	23.06	22
23	Office Manager					23
24	Clerical	1,924	2,171	22,792	10.50	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					31
32	Other Health Care(specify)	1,723	1,936	26,815	13.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,498	105,821	$ 1,424,373 *	$ 13.46	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,013	1-3	35
36	Medical Director		7,403	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,679	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,649	11-3	44
45	Social Service Consultant		2,845	12-3	45
46	Other(specify)		7,176	10-3	46
47			13,332	39-3	47
48			52	39-3	48
49	TOTAL (lines 35 - 48)		$ 42,149		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rebecca Bliss	Admininstrator	0	$ 39,438
Sherry Head	Interim Admin	0	33,302
Clayton Nieman	Interim Admin	0	15,798
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,538

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Sevarus Corp	Survey Tracking	$ 1,461
Old Sevile Waste Consulting	Bio Waste Exp. Reduction	295
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,756

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 10,077
Unemployment Compensation Insurance	12,066
FICA Taxes	97,032
Employee Health Insurance	33,154
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	7,186
Employee Life Insurance	1,205
TOTAL (agree to Schedule V, line 22, col.8)	$ 160,720

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	4,436
(Indicate # of checks performed)	
Patient Background Checks	
Non Allowable Advertising	2,820
Dues	6,677
Other Licenses	2,387
Recruiting	8,959
Publications/Subscriptions	3,378
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	416
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,073

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	20,310
Seminar Expense	5,003
Home Office Allocation	26,011
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 51,324

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn $6,381**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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?

(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? **36 mos**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,078** 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.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **76,102**
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. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BDO Seidman, LLC**

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.