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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0047373

Facility Name: Westchester Hlth & Rehab Ctr

Address: 2901 S Wolf Rd (Number) Westchester (City) 60154 (Zip Code)

County: Cook

Telephone Number: 708-531-1441 **Fax #** 708-409-1271

HFS ID Number:

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

Type of Ownership:

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

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 01/01/2012 to 12/31/2012 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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	120	Skilled (SNF)	120	43,920	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	120	TOTALS	120	43,920	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	27,952	2,948	9,549	40,449	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,952	2,948	9,549	40,449	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.10%

D. How many bed-hold days during this year were paid by the Department?
9 (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 120 and days of care provided 5,143

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	276,509	26,195	23,082	325,786		325,786		325,786			1
2	Food Purchase		230,380		230,380		230,380	(254)	230,126			2
3	Housekeeping	133,340	19,814	22,300	175,454		175,454		175,454			3
4	Laundry	40,100	12,918	13,120	66,138		66,138		66,138			4
5	Heat and Other Utilities			150,498	150,498		150,498	(13,559)	136,939			5
6	Maintenance	30,050	80,456	26,838	137,344		137,344	23,009	160,353			6
7	Other (specify):*			12,990	12,990		12,990		12,990			7
8	**TOTAL General Services**	479,999	369,763	248,828	1,098,590		1,098,590	9,196	1,107,786			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,505,370	189,631	25,476	2,720,477		2,720,477	379,522	3,099,999			10
10a	Therapy	422,277	106,779	207,967	737,023		737,023		737,023			10a
11	Activities	77,993	3,610	20,098	101,701		101,701		101,701			11
12	Social Services	73,757			73,757		73,757		73,757			12
13	CNA Training											13
14	Program Transportation			(64)	(64)		(64)		(64)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,079,397	300,020	277,477	3,656,894		3,656,894	379,522	4,036,416			16
	C. General Administration											
17	Administrative	95,757			95,757		95,757	16,550	112,307			17
18	Directors Fees			525	525		525		525			18
19	Professional Services			29,429	29,429		29,429	28,541	57,970			19
20	Dues, Fees, Subscriptions & Promotions			36,941	36,941		36,941	(36,797)	144			20
21	Clerical & General Office Expenses	288,615	17,544	754,627	1,060,786		1,060,786	(200,593)	860,193			21
22	Employee Benefits & Payroll Taxes			642,662	642,662		642,662	29,431	672,093			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,723	9,723		9,723	58,067	67,790			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			141,028	141,028		141,028	(90,779)	50,249			26
27	Other (specify):*											27
28	**TOTAL General Administration**	384,372	17,544	1,614,935	2,016,851		2,016,851	(195,580)	1,821,271			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,943,768	687,327	2,141,240	6,772,335		6,772,335	193,138	6,965,473			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 Westchester Hlth & Rehab Ctr #0047373 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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			122,904	122,904		122,904	23,106	146,010			30
31	Amortization of Pre-Op. & Org.			6,309	6,309		6,309		6,309			31
32	Interest			(5,038)	(5,038)		(5,038)	(145)	(5,183)			32
33	Real Estate Taxes			320,562	320,562		320,562	(36,817)	283,745			33
34	Rent-Facility & Grounds			531,541	531,541		531,541	13,940	545,481			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							45,254	45,254			36
37	**TOTAL Ownership**			976,278	976,278		976,278	45,338	1,021,616			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,318	25,738	170,056		170,056		170,056			39
40	Barber and Beauty Shops			13,801	13,801		13,801		13,801			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			445,268	445,268		445,268		445,268			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		144,318	484,807	629,125		629,125		629,125			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,943,768	831,645	3,602,325	8,377,738		8,377,738	238,476	8,616,214			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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(171)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,568)	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				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	(83)	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				18
19	Entertainment	(4)	24		19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(25)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(374,788)	21		24
25	Fund Raising, Advertising and Promotional	(38,493)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (427,232)		$	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)	598,829	21	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 598,829		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 171,597		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

Westchester Hlth & Rehab Ctr

ID# 0047373

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Service Fees	$ (428,119)	21	1
2	Professional Liability Insurance Adj	(92,707)	26	2
3	Real Estate Tax Accrual Adj	(36,817)	33	3
4	Remove Rent Averaging	13,940	34	4
5	Adjust Health Insurance to Actual	(11,353)	22	5
6	Adjust Depreciation to Actual	23,106	30	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**	(531,950)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Hlth & Rehab Ctr **#** 0047373 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(254)	0	0	0	0	0	0	0	0	0	0	(254)	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	(13,568)	9	0	0	0	0	0	0	0	0	0	(13,559)	5
6	Maintenance	0	23,009	0	0	0	0	0	0	0	0	0	23,009	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,822)	23,018	0	0	0	0	0	0	0	0	0	9,196	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	379,522	0	0	0	0	0	0	0	0	0	379,522	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	379,522	0	0	0	0	0	0	0	0	0	379,522	16
	C. General Administration													
17	Administrative	0	16,550	0	0	0	0	0	0	0	0	0	16,550	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25)	28,566	0	0	0	0	0	0	0	0	0	28,541	19
20	Fees, Subscriptions & Promotions	(38,493)	1,696	0	0	0	0	0	0	0	0	0	(36,797)	20
21	Clerical & General Office Expenses	(204,178)	3,585	0	0	0	0	0	0	0	0	0	(200,593)	21
22	Employee Benefits & Payroll Taxes	(11,353)	40,784	0	0	0	0	0	0	0	0	0	29,431	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4)	58,071	0	0	0	0	0	0	0	0	0	58,067	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(92,707)	1,928	0	0	0	0	0	0	0	0	0	(90,779)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(346,760)	151,180	0	0	0	0	0	0	0	0	0	(195,580)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(360,582)	553,720	0	0	0	0	0	0	0	0	0	193,138	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westchester Hlth & Rehab Ctr **#** 0047373 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	23,106	0	0	0	0	0	0	0	0	0	0	23,106	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(145)	0	0	0	0	0	0	0	0	0	(145)	32
33	Real Estate Taxes	(36,817)	0	0	0	0	0	0	0	0	0	0	(36,817)	33
34	Rent-Facility & Grounds	13,940	0	0	0	0	0	0	0	0	0	0	13,940	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	45,254	0	0	0	0	0	0	0	0	0	45,254	36
37	**TOTAL Ownership**	229	45,109	0	0	0	0	0	0	0	0	0	45,338	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(360,353)	598,829	0	0	0	0	0	0	0	0	0	238,476	45

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
SSC Equity Holdings LLC	100	Montebello Health Care Center	Hamilton			
		Nature Trail Health CareCenter	Mount Vernon			
		Odin Health Care Center	Odin			
		Westchester Health and Rehab 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. [X] 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%	$ 9	$ 9	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	23,009	23,009	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	28,566	28,566	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	1,696	1,696	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	379,522	379,522	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	3,585	3,585	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	58,071	58,071	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	1,928	1,928	8
9	V	36	Drpreiation		SSC Equity Holdings LLC	100.00%	45,254	45,254	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	16,550	16,550	10
11	V	35	Rental and Lease		SSC Equity Holdings LLC	100.00%			11
12	V	32	Interest Income/Expense		SSC Equity Holdings LLC	100.00%	(145)	(145)	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	40,784	40,784	13
14	Total			$			$ 598,829	$ * 598,829	14

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 PkwyN, 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				$	$		$ 9	1
2	6	Repair and Maintenance							23,009	2
3	19	Professional Services							28,566	3
4	20	Fee, Subscriptions and Promos							1,696	4
5	10	Nursing & Medical Records							379,522	5
6	21	Clerical & Gen Office Exp							3,585	6
7	24	Travel & Seminar							58,071	7
8	26	Insurance							1,928	8
9	36	Drpreiation							45,254	9
10	17	Communications							16,550	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense							(145)	12
13	22	Payroll Taxes							40,784	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					$	$		$ 598,829	25

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 270,340	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.)		$ 283,745	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,405	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 254,154	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.		$ 267,559	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	285,614	8
	2008	280,876	9
	2009	242,745	10
	2010	242,041	11
	2011	242,052	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westchester Hlth & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047373

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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-29-300-018-0000	2901 S Wolf Rd	$ 283,745.00	$ 283,745.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 283,745.00	$ 283,745.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,531 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).

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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	120		2005	1988	$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	12.5 Ton RTU - Kitchen - 50% downpayment			2005	6,484	648	10	648		4,809	9
10	Concrete Sidewalk 1/3 downpayment			2005	1,628	169	12	169		1,070	10
11	12.5 Ton RTU - Kitchen - Balance			2005	6,484	648	10	648		4,755	11
12	Concrete Sidewalk			2005	3,389	304	11.5	304		2,156	12
13	Plumbing Project			2005	4,750	490	11.8	490		3,132	13
14	Plumbing Repairs			2005	10,000	1,031	11.8	1,031		6,594	14
15	Instl Door w/Closer - Exit Device			2005	2,576	272	11.5	272		1,672	15
16	Mixing Valve Spout - Kitchen			2005	2,207	233	11.5	233		1,433	16
17	Dry Sprinkler System Repair			2005	2,159	228	11.5	228		1,402	17
18	Repair Dry Sprinkler System			2005	1,893	200	11.5	200		1,229	18
19	Heat Pump			2005	1,255	133	11.5	133		815	19
20	Double Swing Gates - Dumpster			2005	1,226	153	8	153		1,111	20
21	Heat - Shower Room			2005	19,832	1,983	10	1,983		14,378	21
22	Remove Carpet and Install Tile			2005	37,384	3,738	10	3,738		26,480	22
23											23
24	Emergency Generator			2006	2,907	268	11.25	268		1,818	24
25	Paint Project - Deposit			2006	4,700		5			4,700	25
26	16: 2" Wood Blinds			2006	1,647		5			1,647	26
27	Front Automatic Doors - 50% Deposit			2006	7,122	712	10	712		4,808	27
28	13: Cubicle Curtains W/Mesh			2006	2,037		5			2,037	28
29	16: Single Rod Valances			2006	1,623		5			1,623	29
30	Paint and Light Fixtures			2006	7,050	671	10.5	671		4,476	30
31	16: Wood Blinds			2006	1,718		5			1,718	31
32	15: Cubicle Curtains W/Mesh			2006	2,157		5			2,157	32
33	16: Single Rod Valances			2006	1,631		5			1,631	33
34	Painting Patient Rooms			2006	3,889		5			3,889	34
35	Painting Facility- Down Pmt			2006	4,000		5			4,000	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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
37	Paint and Light Fixture	2006	$ 3,889	$	5	$	$	$ 3,889	37
38	Painting Resident Rooms	2006	4,400		5			4,400	38
39	New Carpet - Admissions Office	2006	4,737		5			4,737	39
40	New Carpet - Admissions Office	2006	148		5			148	40
41	Repair Fire Alarm System	2006	1,778	178	10	178		1,200	41
42	Cove Base/Refurb	2006	2,462		5			2,462	42
43	Use Tax - Cove Base/Refurb	2006	171		5			171	43
44	Painting Resident Rooms - Balance	2006	6,700		5			6,700	44
45	Paint for Refurb	2006	637		5			637	45
46	Paint for Refurb	2006	499		5			499	46
47	Paint for Refurb	2006	360		5			360	47
48	Crash Rails	2006	550	54	10.25	54		345	48
49	Crash Rails for Walls	2006	2,961	284	10.42	284		1,871	49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269	27	10	27		166	51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21	2	10	2		13	52
53	Carpet/Labor	2007	4,440		5			4,440	53
54	Front Automatic Doors - Balance	2007	7,122	712	10	712		4,689	54
55	10: Overbed Lights	2007	1,689	169	10	169		1,069	55
56	Use Tax - 10: Overbed Lights	2007	131	13	10	13		83	56
57	59: Wall Boxes/Sconce Lights	2007	1,675	167	10	167		1,061	57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127	13	10	13		80	58
59	Remodel North & South Front Exit	2007	1,049	108	9.75	108		637	59
60	Heat/Cool Unit	2007	959	98	9.83	98		585	60
61	Connect Kit Heat/AC Unit	2007	46	4	9.83	4		28	61
62	Repair to Walk In Freezer	2007	5,177	522	9.92	522		3,176	62
63	Fire Sprinkler Repair	2007	2,826	285	9.92	285		1,734	63
64	Design Fee	2007	2,900	288	10.08	288		1,798	64
65	Design Fee	2007	225	22	10.08	22		139	65
66	50 Overbed Lights and Wall Sconces	2007	8,572	843	10.16	843		5,340	66
67	50 Overbed Lights and Wall Sconces	2007	664	65	10.16	65		414	67
68	61 Mount Wall Box Sconces	2007	1,741	176	9.92	176		1,068	68
69	61 Mount Wall Box Sconces	2007	135	14	9.92	14		83	69
70	TOTAL (lines 4 thru 69)		$ 210,809	$ 15,925		$ 15,925	$	$ 159,562	70

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 12A, Carried Forward		$ 210,809	$ 15,925		$ 15,925	$	$ 159,562	1
2	29 Oxygen Concentrators	2007	15,536	1,593	9.75	1,593		9,428	2
3	29 Oxygen Concentrators	2007	1,204	123	9.75	123		731	3
4	Cr: Void Ck Village Westchester	2007	(1,049)	(108)	9.75	(108)		(637)	4
5	Permit Fee to Remode;	2007	1,049	109	9.66	109		633	5
6	Connection Kit Heat/Cool Unit	2007	46	5	9.83	5		28	6
7	2 Connect Kits Heat/AC Units	2007	92	9	9.83	9		56	7
8	Cr on Heat/AC Unit	2007	(891)	(91)	9.75	(91)		(541)	8
9	4 Heat/Cool Units	2007	3,564	362	9.83	362		2,174	9
10	4 Power Conn Kits Heat/AC Units	2007	201	20	9.83	20		122	10
11	Furnace Repair	2007	1,380	140	9.83	140		842	11
12	Heat Repair	2007	3,033	303	10	303		2,123	12
13	Repair 8 Heat AC Units	2007	11,700	1,170	10	1,170		8,190	13
14	Boiler Repair	2007	661	68	9.75	68		401	14
15	Remodel North/Southwest Exits	2007	53,930	5,627	9.58	5,627		32,358	15
16	AC Unit	2007	4,835	483	10	483		3,062	16
17	AC Unit	2007	375	37	10	37		237	17
18	Water Heater	2007	1,866	191	9.75	191		1,132	18
19	Stainless Steel End Wall Kitchen	2007	1,261	134	9.41	134		748	19
20									20
21	2:AC Compressor Units	2008	9,874	1,067	9.25	1,067		5,782	21
22	Steel Door	2008	1,675	186	9	186		962	22
23	Furnace 50% Deposit	2008	2,759	315	8.75	315		1,550	23
24	Compressor For Cooling System	2008	3,993	428	9.33	428		2,353	24
25	Furnace -Final Payment	2008	2,759	318	8.66	318		1,538	25
26	Steel Door - Balance	2008	1,675	191	8.75	191		941	26
27	2: Zoneline Heat/Cool Units	2008	1,341	155	8.66	155		748	27
28	Heat Exchanger for Boiler	2008	7,510	875	8.58	875		4,156	28
29	6: Zoneline heat/Cool Units	2008	3,636	727	5	727		3,212	29
30	AT&T Circuit Conversion	2008	32,788	4,015	8.16	4,015		17,398	30
31	AT&T Circuit Conversion	2008	6,306	788	8	788		3,284	31
32	Blower Assembly	2008	3,511	439	8	439		1,829	32
33									33
34	TOTAL (lines 1 thru 33)		$ 387,429	$ 35,604		$ 35,604	$	$ 264,402	34

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 387,429	$ 35,604		$ 35,604	$	$ 264,402	1
2	3: Zoneline Heat/Cool Units	2009	1,999	270	7.42	270		966	2
3	Condenser fan motor	2009	8,348	1,113	7.5	1,113		4,081	3
4	2: Zoneline Heat/Cool Units	2009	1,333	182	7.34	182		636	4
5	Front Entry Paint	2009	6,241	1,248	5	1,248		4,369	5
6	Replace Gaas Valve & Thermometer	2009	2,500	357	7	357		1,131	6
7									7
8	2: Zoneline Heat/Cool Units	2010	1,346	192	7	192		609	8
9	Wanderguard	2010	2,744	387	7	387		1,259	9
10	Attic Sprikler System	2010	33,760	5,128	6.66	5,128		14,102	10
11	Replaced Heat Exchanger	2010	8,224	1,189	6.92	1,189		3,666	11
12	Rplc Furnace Thermostate & Sensor	2010	2,512	363	6.92	363		1,120	12
13	Zoneline Heat/Cool Unit	2010	568	114	5	114		332	13
14	3: Zoneline Heat/Cool Units	2010	1,968	291	6.75	291		850	14
15	Attic Sprikler System	2010	52,686	8,003	0.92	8,003		22,008	15
16	Attic Sprikler System	2010	47,056	7,148	6.92	7,148		19,657	16
17	Rplc Bearing Assembly & Blower Motor	2010	6,357	930	6.83	930		2,791	17
18	Attic Sprikler System	2010	8,025	1,219	6.92	1,219		3,352	18
19	Site Survey	2010	225	36	6.16	36		85	19
20	Compressor Unit	2010	3,102	496	6.16	496		1,199	20
21	Rplc Water Heater	2010	10,077	1,612	6.25	1,612		3,896	21
22	Replace Tempering Valves	2010	4,740	779	6.08	779		1,753	22
23									23
24	Maglock	2011	798	126	6.34	126		315	24
25	3: Zoneline Heat/Cool Units	2011	2,202	440	6	440		881	25
26	Facility Building Sign	2011	2,203	100	6.5	100		367	26
27									27
28	Dry Pendant Sprinkler Heads	2012	5,598	1,233	5	1,233		1,233	28
29	3: Zoneline Heat/Cool Units	2012	2,343	390	5	390		390	29
30	Garbage Disposal	2012	756	75	5	75		75	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 605,140	$		$ 69,025	$	$ 355,525	34

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 433,915	$ 74,482	$ 74,482	$		$ 258,406	71
72	Current Year Purchases	13,415	2,503	2,503			2,503	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 447,330	$ 76,985	$ 76,985	$		$ 260,909	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				$	$	$	$		$	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)	$ 1,052,470	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 76,985	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 146,010	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 69,025	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 616,434	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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. ☐ 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:	1988	120	01/01/2005	$ 545,481	12		3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 545,481 **			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.	/2013	$ 567,300
13.	/2014	$ 589,992
14.	/2015	$ 613,592

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: $ 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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-1	2207 hrs	$ 92,659		$	$	2,207	$ 92,659	1
2	Licensed Speech and Language Development Therapist	10a-1	2094 hrs	97,199				2,094	97,199	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-1	5573 hrs	232,418				5,573	232,418	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				144,318		144,318	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			$ 422,276		$	$ 144,318	9,874	$ 566,594	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.

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 300	$	1
2	Cash-Patient Deposits	358,023		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,843,725		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,593		6
7	Other Prepaid Expenses	3,504		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,207,145	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,764		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	605,139		15
16	Equipment, at Historical Cost	447,332		16
17	Accumulated Depreciation (book methods)	(616,440)		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):	24,712		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 497,507	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,704,652	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,379	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,561		30
31	Accrued Taxes Payable (excluding real estate taxes)	47,152		31
32	Accrued Real Estate Taxes(Sch.IX-B)	283,745		32
33	Accrued Interest Payable			33
34	Deferred Compensation	99,781		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Taxes (Other)	168,011		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,001,629	$	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		1,629,002		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,629,002	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,630,631	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,021	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,704,652	$	48

***(See instructions.)**

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (131,056)	1	
2	Restatements (describe):	(16,561)	2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (147,617)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	221,638	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)**	$ 221,638	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)**	$ 74,021	24	*

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,018,569	1
2	Discounts and Allowances for all Levels	(1,049,078)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,969,491	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,178,005	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,178,005	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	18,253	13
14	Non-Patient Meals	186	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	362,500	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,254	19
20	Radiology and X-Ray	14,938	20
21	Other Medical Services	25,136	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 450,267	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Revenue	1,326	28
28a	Activities Revenue	257	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,583	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,599,376	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,098,590	31
32	Health Care	3,656,894	32
33	General Administration	2,016,851	33
	B. Capital Expense		
34	Ownership	976,278	34
	C. Ancillary Expense		
35	Special Cost Centers	183,857	35
36	Provider Participation Fee	445,268	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,377,738	40
41	**Income before Income Taxes (line 30 minus line 40)****	221,638	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 221,638	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,321,689	44
45	Private Pay - Net Inpatient Revenue	859,154	45
46	Medicare - Net Inpatient Revenue	1,150,208	46
47	Other-(specify) HMO/Ins	104,088	47
48	Other-(specify) VA/Hospice	534,352	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,969,491	49

* **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.**

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,943	2,087	$ 88,467	$ 42.39	1
2	Assistant Director of Nursing	918	966	36,558	37.84	2
3	Registered Nurses	10,226	11,025	363,514	32.97	3
4	Licensed Practical Nurses	35,381	38,175	1,062,916	27.84	4
5	CNAs & Orderlies	73,109	78,968	938,667	11.89	5
6	CNA Trainees					6
7	Licensed Therapist	9,239	9,875	422,277	42.76	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,924	2,133	50,145	23.51	9
10	Activity Assistants	2,255	2,444	27,847	11.39	10
11	Social Service Workers	3,173	3,472	73,757	21.24	11
12	Dietician					12
13	Food Service Supervisor	1,799	2,090	47,118	22.54	13
14	Head Cook	5,945	6,524	101,746	15.60	14
15	Cook Helpers/Assistants	13,195	15,148	127,646	8.43	15
16	Dishwashers					16
17	Maintenance Workers	1,746	1,990	30,050	15.10	17
18	Housekeepers	11,861	13,006	133,340	10.25	18
19	Laundry	3,182	3,681	40,100	10.89	19
20	Administrator	2,031	2,163	95,757	44.27	20
21	Assistant Administrator					21
22	Other Administrative	5,931	6,689	188,969	28.25	22
23	Office Manager					23
24	Clerical	4,758	5,280	99,646	18.87	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	991	991	15,248	15.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,607	206,707	$ 3,943,768 *	$ 19.08	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		$ 20,511	1-3	35
36	Medical Director		24,000	9-3	36
37	Medical Records Consultant		4,904	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,195	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		2,295	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		20,050	11-3	44
45	Social Service Consultant				45
46	Other(specify) Admin		45,878	10-3	46
47	Xray/ Laboratory		14,809	39-3	47
48	Dentist/Physician/Psychiatrist		741	39-3	48
49	TOTAL (lines 35 - 48)		$ 140,383		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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Renee Bogard	Administrator	0	$ 10,335
Sue Bohne	Interim Admin	0	35,640
Carolyn R McBrider	Interim Admin	0	31,320
Martin T Lee	Administrator	0	18,462
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,757

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	$ 763
Old Seville Waste Consulting	Waste Reduction	2,975
ADP	WOTC Tracking	824
CT Corp	Litigation Tracking	256
My Innerview	Resident Survey	280
Legal	Legal	25
GenPact	Reengineering Cost Analysis	6,802
TALX	Unemployment Tracking	683
LexisNexi	Risk Data Service	56
Waste Reduction Consultants	Waste Reduction	1,694
Vengroff Williams & Assoc	Collection Service	15,071
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 29,429

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,721
Unemployment Compensation Insurance	68,812
FICA Taxes	288,800
Employee Health Insurance	179,582
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Insurance Life	3,329
Other Benefits	10,065
Home Office PR Taxes	40,784
TOTAL (agree to Schedule V, line 22, col.8)	$ 672,093

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 8,596
Advertising: Employee Recruitment	6,049
Health Care Worker Background Check	5,423
(Indicate # of checks performed)	
Patient Background Checks	
Pulications & Manuals	3,113
Other Licenses	1,644
Home Office Subs/Fees	1,696
Non Allowable Adv	(27,327)
Other Dues	950
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 144

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,103
In-State Travel	2,560
Seminar Expense	4,060
Home Office Travel	58,067
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 67,790

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Westchester Hlth & Rehab Ctr **#** 0047373 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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 $8596**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,220** 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. $ **445,268**
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? **Yes** Indicate the amount. $ **171**

(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?
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

(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.