FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

I. IDPH License ID Number: 0047373

Facility Name: Westchester Hlth & Rehab Ctr

Address: 2901 South Wolf Road (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 01/01/2013 to 12/31/2013 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: 01/01/2013 Ending: 12/31/2013

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	43,800	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	43,800	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	31,527	2,218	8,497	42,242	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,527	2,218	8,497	42,242	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.44%

D. How many bed-hold days during this year were paid by the Department?
2 (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 5,828

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	283,603	25,242	22,224	331,069		331,069		331,069			1
2	Food Purchase		248,682		248,682		248,682	(65)	248,617			2
3	Housekeeping		2,829	155,529	158,358		158,358		158,358			3
4	Laundry		12,192	101,760	113,952		113,952		113,952			4
5	Heat and Other Utilities			166,286	166,286		166,286	(14,884)	151,402			5
6	Maintenance	47,884	155,838	21,204	224,926		224,926	30,979	255,905			6
7	Other (specify):*			13,252	13,252		13,252		13,252			7
8	**TOTAL General Services**	331,487	444,783	480,255	1,256,525		1,256,525	16,030	1,272,555			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	2,350,528	189,501	27,412	2,567,441		2,567,441	345,121	2,912,562			10
10a	Therapy	482,166	88,831	61,614	632,611		632,611		632,611			10a
11	Activities	74,585	6,639	18,056	99,280		99,280		99,280			11
12	Social Services	84,397	8		84,405		84,405		84,405			12
13	CNA Training											13
14	Program Transportation		27	50	77		77		77			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,991,676	285,006	120,932	3,397,614		3,397,614	345,121	3,742,735			16
	C. General Administration											
17	Administrative	107,223			107,223		107,223	9,179	116,402			17
18	Directors Fees			525	525		525		525			18
19	Professional Services			21,218	21,218		21,218	27,418	48,636			19
20	Dues, Fees, Subscriptions & Promotions			38,189	38,189		38,189	(8,722)	29,467			20
21	Clerical & General Office Expenses	265,099	15,762	477,101	757,962		757,962	(595,763)	162,199			21
22	Employee Benefits & Payroll Taxes			416,644	416,644		416,644	59,583	476,227			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,321	8,321		8,321	54,163	62,484			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			142,464	142,464		142,464	89,304	231,768			26
27	Other (specify):*											27
28	**TOTAL General Administration**	372,322	15,762	1,104,462	1,492,546		1,492,546	(364,838)	1,127,708			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,695,485	745,551	1,705,649	6,146,685		6,146,685	(3,687)	6,142,998			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:** 01/01/2013 **Ending:** 12/31/2013

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			129,993	129,993		129,993	179	130,172			30
31	Amortization of Pre-Op. & Org.			6,309	6,309		6,309		6,309			31
32	Interest			(77,733)	(77,733)		(77,733)		(77,733)			32
33	Real Estate Taxes			278,101	278,101		278,101	20,974	299,075			33
34	Rent-Facility & Grounds			573,445	573,445		573,445	40,108	613,553			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* HO Depr/Franchise Tax			250	250		250	57,339	57,589			36
37	**TOTAL Ownership**			910,365	910,365		910,365	118,600	1,028,965			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		155,035	37,386	192,421		192,421		192,421			39
40	Barber and Beauty Shops			12,807	12,807		12,807		12,807			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,219	285,219		285,219		285,219			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		155,035	335,412	490,447		490,447		490,447			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,695,485	900,586	2,951,426	7,547,497		7,547,497	114,913	7,662,410			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: 01/01/2013 Ending: 12/31/2013

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				4
5	Telephone, TV & Radio in Resident Rooms	(14,900)	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	(65)	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	(819)	21		18
19	Entertainment				19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,820)	22		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(113,094)	21		24
25	Fund Raising, Advertising and Promotional	(10,327)	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	(315,082)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (467,207)		$	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)	582,120		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 582,120		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 114,913		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

STATE OF ILLINOIS **Page 5A**

Westchester Hlth & Rehab Ctr

ID# **0047373**

Report Period Beginning: **01/01/2013**

Ending: **12/31/2013**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services Fees	$ (418,792)	21	1
2	Professional Liability Insurance Adj	82,703	26	2
3	Real Estate Tax Accrual Adjustment	20,974	33	3
4	Remove Rent Averaging	40,108	34	4
5	Adjust Health Insurance to Actual	26,927	22	5
6	Adjust Depreciation to Actual	179	30	6
7	Non Allowable Marketing Wages	(67,181)	21	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**	(315,082)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Hlth & Rehab Ctr **#** 0047373 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(65)	0	0	0	0	0	0	0	0	0	0	(65)	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	(14,900)	16	0	0	0	0	0	0	0	0	0	(14,884)	5
6	Maintenance	0	30,979	0	0	0	0	0	0	0	0	0	30,979	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,965)	30,995	0	0	0	0	0	0	0	0	0	16,030	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	345,121	0	0	0	0	0	0	0	0	0	345,121	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	345,121	0	0	0	0	0	0	0	0	0	345,121	16
	C. General Administration													
17	Administrative	0	9,179	0	0	0	0	0	0	0	0	0	9,179	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	27,418	0	0	0	0	0	0	0	0	0	27,418	19
20	Fees, Subscriptions & Promotions	(10,327)	1,605	0	0	0	0	0	0	0	0	0	(8,722)	20
21	Clerical & General Office Expenses	(599,986)	4,223	0	0	0	0	0	0	0	0	0	(595,763)	21
22	Employee Benefits & Payroll Taxes	14,107	45,476	0	0	0	0	0	0	0	0	0	59,583	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	54,163	0	0	0	0	0	0	0	0	0	54,163	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	82,703	6,601	0	0	0	0	0	0	0	0	0	89,304	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(513,503)	148,665	0	0	0	0	0	0	0	0	0	(364,838)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(528,468)	524,781	0	0	0	0	0	0	0	0	0	(3,687)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westchester Hlth & Rehab Ctr **#** 0047373 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	179	0	0	0	0	0	0	0	0	0	0	179	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	20,974	0	0	0	0	0	0	0	0	0	0	20,974	33
34	Rent-Facility & Grounds	40,108	0	0	0	0	0	0	0	0	0	0	40,108	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	57,339	0	0	0	0	0	0	0	0	0	57,339	36
37	**TOTAL Ownership**	61,261	57,339	0	0	0	0	0	0	0	0	0	118,600	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)**	(467,207)	582,120	0	0	0	0	0	0	0	0	0	114,913	45

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Care Center	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. ☐ 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%	$ 16	$ 16	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	30,979	30,979	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	27,418	27,418	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	1,605	1,605	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	345,121	345,121	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	4,223	4,223	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	54,163	54,163	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	6,601	6,601	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	57,339	57,339	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	9,179	9,179	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%			12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	45,476	45,476	13
14	Total			$			$ 582,120	$ * 582,120	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: 01/01/2013 Ending: 12/31/2013

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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: 01/01/2013 Ending: 2/31/2013

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 Pkwy 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				$	$		$ 16	1
2	6	Repair and Maintenance							30,979	2
3	19	Professional Services							27,418	3
4	20	Fee, Subscriptions and Promos							1,605	4
5	10	Nursing & Medical Records							345,121	5
6	21	Clerical & Gen Office Exp							4,223	6
7	24	Travel & Seminar							54,163	7
8	26	Insurance							6,601	8
9	36	Drpreiation							57,339	9
10	17	Communications							9,179	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense								12
13	22	Payroll Taxes							45,476	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					$	$		$ 582,120	25

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 254,154	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.)		$ 299,075	2
3. Under or (over) accrual (line 2 minus line 1).		$ 44,921	3
4. Real Estate Tax accrual used for 2013 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.		$ 299,075	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	280,876	8
	2009	242,745	9
	2010	242,041	10
	2011	242,052	11
	2012	283,745	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 832467-6317 FAX #: 832-467-6983

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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	$ 299,075.00	$ 299,075.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 299,075.00	$ 299,075.00

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/2013 Ending: 12/31/2013

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).

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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			2005		$	$		$	$	$	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		5,457	9
10	Concrete Sidewalk 1/3 downpayment			2005	1,628	143	12	143		1,212	10
11	12.5 Ton RTU - Kitchen - Balance			2005	6,484	648	10	648		5,403	11
12	Concrete Sidewalk			2005	3,389	(157)	11.5	(157)		1,999	12
13	Plumbing Project			2005	4,750	413	11.8	413		3,545	13
14	Plumbing Repairs			2005	10,000	870	11.8	870		7,464	14
15	Instl Door w/Closer - Exit Device			2005	2,576	231	11.5	231		1,903	15
16	Mixing Valve Spout - Kitchen			2005	2,207	198	11.5	198		1,630	16
17	Dry Sprinkler System Repair			2005	2,159	193	11.5	193		1,595	17
18	Repair Dry Sprinkler System			2005	1,893	170	11.5	170		1,399	18
19	Heat Pump			2005	1,255	112	11.5	112		927	19
20	Double Swing Gates - Dumpster			2005	1,226	115	8	115		1,226	20
21	Heat - Shower Room			2005	19,832	1,983	10	1,983		16,362	21
22	Remove Carpet and Install Tile			2005	37,384	3,738	10	3,738		30,219	22
23											23
24	Emergency Generator			2006	2,907	(139)	11.25	(139)		1,680	24
25	Paint Project - Deposit			2006	4,700		5			4,700	25
26	16: 2" Wood Blinds			2006	1,647		5			1,648	26
27	Front Automatic Doors - 50% Deposit			2006	7,122	712	10	712		5,520	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	631	10.5	631		5,107	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: 01/01/2013 Ending: 12/31/2013

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		1,378	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	50	10.25	50		395	48
49	Crash Rails for Walls	2006	2,961	267	10.42	267		2,139	49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269	27	10	27		193	51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21	2	10	2		15	52
53	Carpet/Labor	2007	4,440		5			4,440	53
54	Front Automatic Doors - Balance	2007	7,122	712	10	712		5,401	54
55	10: Overbed Lights	2007	1,689	169	10	169		1,238	55
56	Use Tax - 10: Overbed Lights	2007	131	13	10	13		96	56
57	59: Wall Boxes/Sconce Lights	2007	1,675	168	10	168		1,228	57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127	13	10	13		93	58
59	Remodel North & South Front Exit	2007	1,049	101	9.75	101		738	59
60	Heat/Cool Unit	2007	959	92	9.83	92		677	60
61	Connect Kit Heat/AC Unit	2007	46	4	9.83	4		32	61
62	Repair to Walk In Freezer	2007	5,177	491	9.92	491		3,667	62
63	Fire Sprinkler Repair	2007	2,826	268	9.92	268		2,002	63
64	Design Fee	2007	2,900	271	10.08	271		2,068	64
65	Design Fee	2007	225	21	10.08	21		160	65
66	50 Overbed Lights and Wall Sconces	2007	8,572	793	10.16	793		6,133	66
67	50 Overbed Lights and Wall Sconces	2007	664	61	10.16	61		475	67
68	61 Mount Wall Box Sconces	2007	1,741	165	9.92	165		1,233	68
69	61 Mount Wall Box Sconces	2007	135	13	9.92	13		96	69
70	TOTAL (lines 4 thru 69)		$ 210,809	$ 14,388		$ 14,388	$	$ 173,951	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: 01/01/2013 Ending: 12/31/2013

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	$ 14,388		$ 14,388	$	$ 173,951	1
2	29 Oxygen Concentrators	2007	15,536	1,500	9.75	1,500		10,928	2
3	29 Oxygen Concentrators	2007	1,204	116	9.75	116		847	3
4	Cr: Void Ck Village Westchester	2007	(1,049)	(101)	9.75	(101)		(738)	4
5	Permit Fee to Remode;	2007	1,049	102	9.66	102		735	5
6	Connection Kit Heat/Cool Unit	2007	46	4	9.83	4		32	6
7	2 Connect Kits Heat/AC Units	2007	92	9	9.83	9		65	7
8	Cr on Heat/AC Unit	2007	(891)	(86)	9.75	(86)		(627)	8
9	4 Heat/Cool Units	2007	3,564	341	9.83	341		2,516	9
10	4 Power Conn Kits Heat/AC Units	2007	201	19	9.83	19		142	10
11	Furnace Repair	2007	1,380	132	9.83	132		974	11
12	Heat Repair	2007	3,033	303	10	303		2,427	12
13	Repair 8 Heat AC Units	2007	11,700	1,170	10	1,170		9,360	13
14	Boiler Repair	2007	661	64	9.75	64		465	14
15	Remodel North/Southwest Exits	2007	53,930	5,300	9.58	5,300		37,658	15
16	AC Unit	2007	4,835	483	10	483		3,545	16
17	AC Unit	2007	375	37	10	37		275	17
18	Water Heater	2007	1,866	180	9.75	180		1,313	18
19	Stainless Steel End Wall Kitchen	2007	1,261	126	9.41	126		874	19
20									20
21	2:AC Compressor Units	2008	9,874	1,006	9.25	1,006		6,788	21
22	Steel Door	2008	1,675	176	9	176		1,137	22
23	Furnace 50% Deposit	2008	2,759	298	8.75	298		1,848	23
24	Compressor For Cooling System	2008	3,993	403	9.33	403		2,756	24
25	Furnace -Final Payment	2008	2,759	301	8.66	301		1,839	25
26	Steel Door - Balance	2008	1,675	181	8.75	181		1,122	26
27	2: Zoneline Heat/Cool Units	2008	1,341	146	8.66	146		894	27
28	Heat Exchanger for Boiler	2008	7,510	827	8.58	827		4,983	28
29	6: Zoneline heat/Cool Units	2008	3,636	424	5	424		3,636	29
30	AT&T Circuit Conversion	2008	32,788	3,799	8.16	3,799		21,196	30
31	AT&T Circuit Conversion	2008	6,306	746	8	746		4,031	31
32	Blower Assembly	2008	3,511	416	8	416		2,244	32
33									33
34	TOTAL (lines 1 thru 33)		$ 387,429	$ 32,810		$ 32,810	$	$ 297,216	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: 01/01/2013 Ending: 12/31/2013

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	$ 32,810		$ 32,810	$	$ 297,216	1
2	3: Zoneline Heat/Cool Units	2009	1,999	256	7.42	256		1,221	2
3	Condenser fan motor	2009	8,348	1,056	7.5	1,056		5,137	3
4	2: Zoneline Heat/Cool Units	2009	1,333	173	7.34	173		808	4
5	Front Entry Paint	2009	6,241	1,248	5	1,248		5,617	5
6	Replace Gaas Valve & Thermometer	2009	2,500	340	7	340		1,470	6
7									7
8	2: Zoneline Heat/Cool Units	2010	1,346	183	7	183		792	8
9	Wanderguard	2010	2,744	368	7	368		1,628	9
10	Attic Sprikler System	2010	33,760	4,888	6.66	4,888		18,990	10
11	Replaced Heat Exchanger	2010	8,224	1,131	6.92	1,131		4,797	11
12	Rplc Furnace Thermostate & Sensor	2010	2,512	346	6.92	346		1,465	12
13	Zoneline Heat/Cool Unit	2010	568	114	5	114		445	13
14	3: Zoneline Heat/Cool Units	2010	1,968	278	6.75	278		1,128	14
15	Attic Sprikler System	2010	52,686	7,628	0.92	7,628		29,636	15
16	Attic Sprikler System	2010	47,056	6,813	6.92	6,813		26,469	16
17	Rplc Bearing Assembly & Blower Motor	2010	6,357	885	6.83	885		3,676	17
18	Attic Sprikler System	2010	8,025	1,219	6.92	1,219		4,571	18
19	Site Survey	2010	225	35	6.16	35		120	19
20	Compressor Unit	2010	3,102	474	6.16	474		1,673	20
21	Rplc Water Heater	2010	10,077	1,540	6.25	1,540		5,436	21
22	Replace Tempering Valves	2010	4,740	745	6.08	745		2,498	22
23									23
24	Maglock	2011	798	120	6.34	120		436	24
25	3: Zoneline Heat/Cool Units	2011	2,202	440	6	440		1,321	25
26	Facility Building Sign	2011	2,203	670	6.5	670		1,037	26
27								2,294	27
28	Dry Pendant Sprinkler Heads	2012	5,598	1,061	5	1,061			28
29	3: Zoneline Heat/Cool Units	2012	2,343	498	5	498		889	29
30	Garbage Disposal	2012	756	176	5	176		252	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 605,140	$ 65,495		$ 65,495	$	$ 421,022	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: 01/01/2013 Ending: 12/31/2013

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 12C, Carried Forward		$ 605,140	$ 65,495		$ 65,495	$	$ 421,022	1
2	Mixing Valves	2013	5,790	1,355	44	1,355		1,355	2
3	Heat Draft Inducer Motor	2013	4,043	946	4	946		946	3
4	Aluminum Light Pole	2013	3,200	849	4	849		849	4
5	Inducer	2013	3,571	836	3.75	836		836	5
6	5: Duct Detectors	2013	3,035	607	3.75	607		607	6
7	Inducer - Credit Memo	2013	(689)	(150)	3.83	(150)		(150)	7
8	A/C Motor Kitchen Area	2013	1,642	328	3.75	328		328	8
9	Relays for Duct Smoke Detector	2013	1,000	182	3.67	182		182	9
10	19: Damper Actuators	2013	4,370	711	3.58	711		711	10
11	12: Damper Actuators	2013	1,338	218	3.58	218		218	11
12	Generator Transfer Switch	2013	4,722	769	3.58	769		769	12
13	12 Damper Actuators	2013	1,338	218	3.58	218		218	13
14	A/C Compressor Unit #1	2013	3,668	524	3.5	524		524	14
15	A/C Compressor & Condenser Fan	2013	3,580	437	3.42	437		437	15
16	Hot Water Booster Heater - Dishwasher	2013	2,529	308	3.42	308		308	16
17	7: Exhaust Vents	2013	1,332	102	3.25	102		102	17
18	Motor for Unit #8	2013	2,268	174	3.25	174		174	18
19	Bearing Assembly Water Heater	2013	2,960	228	3.25	228		228	19
20	Gas Valve and Ignition Control	2013	2,294	121	3.17	121		121	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 657,131	$ 74,258		$ 74,258	$	$ 429,785	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: 01/01/2013 Ending: 12/31/2013

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	$ 447,330	$ 53,381	$ 53,381	$		$ 314,291	71
72	Current Year Purchases	14,086	2,532	2,532			2,532	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 461,416	$ 55,913	$ 55,913	$		$ 316,823	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)	$ 1,118,547	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,171	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,171	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 746,608	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: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SSC Equity 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:	1988	120	01/01/2005	$ 613,553	12		3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 613,553 **			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.	/2014	$ 589,992
13.	/2015	$ 613,592
14.	/2016	$ 638,136

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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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-03	4050 hrs	$ 163,455		$	$	4,050	$ 163,455	1
2	Licensed Speech and Language Development Therapist	10a-03	1153 hrs	56,041				1,153	56,041	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	6290 hrs	262,669				6,290	262,669	4
5	Physician Care	39	visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				155,035		155,035	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			$ 482,165		$	$ 155,035	11,493	$ 637,200	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 Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (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	73,189		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,608,042		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,651		6
7	Other Prepaid Expenses	1,515		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,689,697	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	58,625		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	657,131		15
16	Equipment, at Historical Cost	461,418		16
17	Accumulated Depreciation (book methods)	(746,554)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	90,734		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	18,403		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 539,757	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,229,454	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 178,646	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	274,965		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,499		31
32	Accrued Real Estate Taxes(Sch.IX-B)	297,932		32
33	Accrued Interest Payable			33
34	Deferred Compensation	98,007		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Taxes (Other)	152,065		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,003,114	$	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 Revolver/Other	358,992		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 358,992	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,362,106	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 867,348	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,229,454	$	48

*(See instructions.)

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 74,021	1	
2	Restatements (describe):	(54,960)	2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 19,061	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	848,287	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)**	$ 848,287	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)**	$ 867,348	24	*

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 8,254,666	1
2	Discounts and Allowances for all Levels	(1,358,767)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,895,899	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,096,170	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,096,170	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	17,676	13
14	Non-Patient Meals	430	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	322,898	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,365	19
20	Radiology and X-Ray	17,871	20
21	Other Medical Services	12,635	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 401,875	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Receipts - Admin	53	28
28a	Vending Receipts	1,787	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,840	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,395,784	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,256,525	31
32	Health Care	3,397,614	32
33	General Administration	1,492,546	33
	B. Capital Expense		
34	Ownership	910,365	34
	C. Ancillary Expense		
35	Special Cost Centers	205,228	35
36	Provider Participation Fee	285,219	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,547,497	40
41	**Income before Income Taxes (line 30 minus line 40)****	848,287	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 848,287	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,540,846	44
45	Private Pay - Net Inpatient Revenue	604,339	45
46	Medicare - Net Inpatient Revenue	1,414,511	46
47	Other-(specify)	31,569	47
48	Other-(specify)	304,634	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,895,899	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: 01/01/2013 Ending: 12/31/2013

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	1,831	2,079	$ 86,228	$ 41.48	1
2	Assistant Director of Nursing	1,418	1,642	59,343	36.14	2
3	Registered Nurses	8,199	8,932	297,600	33.32	3
4	Licensed Practical Nurses	34,039	36,913	1,002,669	27.16	4
5	CNAs & Orderlies	70,378	75,342	900,384	11.95	5
6	CNA Trainees					6
7	Licensed Therapist	10,765	11,493	482,166	41.95	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,962	2,171	49,407	22.76	9
10	Activity Assistants	1,986	2,160	25,178	11.66	10
11	Social Service Workers	3,726	4,110	84,397	20.53	11
12	Dietician					12
13	Food Service Supervisor	1,837	2,085	48,089	23.06	13
14	Head Cook	6,325	6,808	102,910	15.12	14
15	Cook Helpers/Assistants	14,365	15,293	132,605	8.67	15
16	Dishwashers					16
17	Maintenance Workers	1,991	2,087	47,884	22.94	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,975	2,087	108,519	52.00	20
21	Assistant Administrator					21
22	Other Administrative	5,516	6,064	208,498	34.38	22
23	Office Manager					23
24	Clerical	2,972	3,430	55,304	16.12	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	279	279	4,305	15.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,564	182,975	$ 3,695,486 *	$ 20.20	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		$ 19,952	1-3	35
36	Medical Director		13,800	9-3	36
37	Medical Records Consultant		4,232	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,270	10a-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		676	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		16,823	11-3	44
45	Social Service Consultant			12-3	45
46	Other(specify) Admin		37,811	10-3	46
47	Xray & Lab		27,191	39-3	47
48	Dentist/Physician/Psychiatrist		804	39-3	48
49	TOTAL (lines 35 - 48)		$ 130,559		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: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Martn T Lee	Administrator		$ 107,223
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,223

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/Cass Info	Survey Tracking	$ 664
Old Seville Waste Consulting	Waste Reduction	1,488
Point Right/Point Click Care		1,520
CT Corp	Litigation Tracking	256
My Innerview/Laminex/Equifax	Resident Survey	357
Legal	Legal	10,240
GenPact	Reengineering Cost Analysis	1,080
TALX	Unemployment Tracking	686
LexisNexis	Risk Data Service	158
Waste Reduction Consultants	Waste Reduction	1,138
Schutjer Bogar LLC	Collection Service	2,961
National Research	Quality Care Analysis	670
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,218

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,956
Unemployment Compensation Insurance	67,428
FICA Taxes	267,103
Employee Health Insurance	12,987
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Ins	2,884
Other Benefits	6,214
Home Office PR Taxes	45,476
Legal	(12,820)
TOTAL (agree to Schedule V, line 22, col.8)	$ 476,228

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	$ 1,990
Advertising: Employee Recruitment	10,767
Health Care Worker Background Check	5,420
(Indicate # of checks performed)	
Patient Background Checks	
Publications and Manuals	1,451
Dues	9,589
Other Licenses	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,467

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,959
In-State Travel	1,387
Seminar Expense	4,971
Home Office Travel and Seminar	54,163
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 62,480

**See instructions.

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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 Assocation $7984**

(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? **12 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,898** 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. $ **285,219**
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? **No** 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? **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 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.