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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 McDanielllll **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 01/01/2014 to 12/31/2014 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 & Reimbursment

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: 01/01/2014 Ending: 12/31/2014

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	30,850	2,966	8,422	42,238	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,850	2,966	8,422	42,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.43%

D. How many bed-hold days during this year were paid by the Department?
26 (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)
NA

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 5,452

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	272,389	29,774	68,897	371,060		371,060		371,060			1
2	Food Purchase		237,707		237,707		237,707	(136)	237,571			2
3	Housekeeping		10,009	143,963	153,972		153,972		153,972			3
4	Laundry		20,590	95,948	116,538		116,538		116,538			4
5	Heat and Other Utilities			208,691	208,691		208,691	(18,200)	190,491			5
6	Maintenance	47,546	149,278	21,039	217,863		217,863	37,391	255,254			6
7	Other (specify):*			14,827	14,827		14,827		14,827			7
8	**TOTAL General Services**	319,935	447,358	553,365	1,320,658		1,320,658	19,055	1,339,713			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	2,466,613	190,041	38,709	2,695,363		2,695,363	439,734	3,135,097			10
10a	Therapy	498,488	75,568	77,636	651,692		651,692		651,692			10a
11	Activities	74,728	9,026	20,388	104,142		104,142		104,142			11
12	Social Services	90,308		1,468	91,776		91,776		91,776			12
13	CNA Training											13
14	Program Transportation		20	196	216		216		216			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,130,137	274,655	155,197	3,559,989		3,559,989	439,734	3,999,723			16
	C. General Administration											
17	Administrative	102,220			102,220		102,220	11,106	113,326			17
18	Directors Fees			525	525		525		525			18
19	Professional Services			39,739	39,739		39,739	(14,760)	24,979			19
20	Dues, Fees, Subscriptions & Promotions			35,557	35,557		35,557	18,065	53,622			20
21	Clerical & General Office Expenses	216,267	18,930	681,290	916,487		916,487	(724,294)	192,193			21
22	Employee Benefits & Payroll Taxes			672,793	672,793		672,793	55,619	728,412			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,430	6,430		6,430	71,023	77,453			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			129,394	129,394		129,394	83,973	213,367			26
27	Other (specify):*							300	300			27
28	**TOTAL General Administration**	318,487	18,930	1,565,728	1,903,145		1,903,145	(498,968)	1,404,177			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,768,559	740,943	2,274,290	6,783,792		6,783,792	(40,179)	6,743,613			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: 01/01/2014 Ending: 12/31/2014

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			148,166	148,166		148,166	15	148,181			30
31	Amortization of Pre-Op. & Org.			4,611	4,611		4,611		4,611			31
32	Interest			(8,273)	(8,273)		(8,273)	38,933	30,660			32
33	Real Estate Taxes			345,744	345,744		345,744	9,166	354,910			33
34	Rent-Facility & Grounds			1,039,730	1,039,730		1,039,730	(96,979)	942,751			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							72,503	72,503			36
37	**TOTAL Ownership**			1,529,978	1,529,978		1,529,978	23,638	1,553,616			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,920	39,025	165,945		165,945		165,945			39
40	Barber and Beauty Shops			9,458	9,458		9,458		9,458			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			287,636	287,636		287,636		287,636			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		126,920	336,119	463,039		463,039		463,039			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,768,559	867,863	4,140,387	8,776,809		8,776,809	(16,541)	8,760,268			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: 01/01/2014 Ending: 12/31/2014

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	(53)	2		4
5	Telephone, TV & Radio in Resident Rooms	(18,273)	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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28,565)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,534)	21		24
25	Fund Raising, Advertising and Promotional	(53,350)	21		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	(466,589)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (787,447)		$	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)	770,906		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 770,906		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (16,541)		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: **01/01/2014**

Ending: **12/31/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services Fees	$ (454,091)	21	1
2	Professional Liability Insurance Adj	75,000	26	2
3	Real Estate Tax Accrual Adjustment	9,466	33	3
4	Remove Rent Averaging	(96,979)	34	4
5	Adjust Health Insurance to Actual		22	5
6	Adjust Depreciation to Actual	15	30	6
7	Reclass Franchise Tax	(300)	33	7
8	Reclass Franchise Tax	300	27	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**	(466,589)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Hlth & Rehab Ctr **#** 0047373 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(136)	0	0	0	0	0	0	0	0	0	0	(136)	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	(18,273)	73	0	0	0	0	0	0	0	0	0	(18,200)	5
6	Maintenance	0	37,391	0	0	0	0	0	0	0	0	0	37,391	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,409)	37,464	0	0	0	0	0	0	0	0	0	19,055	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	439,734	0	0	0	0	0	0	0	0	0	439,734	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	439,734	0	0	0	0	0	0	0	0	0	439,734	16
	C. General Administration													
17	Administrative	0	11,106	0	0	0	0	0	0	0	0	0	11,106	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(28,565)	13,805	0	0	0	0	0	0	0	0	0	(14,760)	19
20	Fees, Subscriptions & Promotions	0	18,065	0	0	0	0	0	0	0	0	0	18,065	20
21	Clerical & General Office Expenses	(727,975)	3,681	0	0	0	0	0	0	0	0	0	(724,294)	21
22	Employee Benefits & Payroll Taxes	0	55,619	0	0	0	0	0	0	0	0	0	55,619	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	71,023	0	0	0	0	0	0	0	0	0	71,023	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	75,000	8,973	0	0	0	0	0	0	0	0	0	83,973	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	**TOTAL General Administration**	(681,240)	182,272	0	0	0	0	0	0	0	0	0	(498,968)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(699,649)	659,470	0	0	0	0	0	0	0	0	0	(40,179)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westchester Hlth & Rehab Ctr **#** 0047373 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	15	0	0	0	0	0	0	0	0	0	0	15	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	38,933	0	0	0	0	0	0	0	0	0	38,933	32
33	Real Estate Taxes	9,166	0	0	0	0	0	0	0	0	0	0	9,166	33
34	Rent-Facility & Grounds	(96,979)	0	0	0	0	0	0	0	0	0	0	(96,979)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	72,503	0	0	0	0	0	0	0	0	0	72,503	36
37	**TOTAL Ownership**	(87,798)	111,436	0	0	0	0	0	0	0	0	0	23,638	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)**	(787,447)	770,906	0	0	0	0	0	0	0	0	0	(16,541)	45

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		Montebello Health Care Center	Hamilton	SWC Equity Holdings LLC		Holding Company
		Nature Trail Health Care Center	Mount Vernon	SSC Administrative Services LLC		Back Office Service
		Odin Health Care Center	Odin	SSC Consulting Services		Operations and Con
		Westchester Health and Rehab Center	Westchester			
		Brentwood Sub Acute Healthcare Center	Burbank			

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%	$ 73	$ 73	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	37,391	37,391	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	13,805	13,805	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	18,065	18,065	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	439,734	439,734	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	3,681	3,681	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	71,023	71,023	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	8,973	8,973	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	72,503	72,503	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	11,106	11,106	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%	38,933	38,933	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	55,619	55,619	13
14	Total			$			$ 770,906	$ * 770,906	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: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC	100	Cedar Crest	Montgomery				1
2			Fairview Health & Rehab Center	Birmingham				2
3			Montrose Bay Healthcare Center	Fairhope				3
4			South Haven Health & Rehab Center	Montgomery				4
5			Warren Manor	Selma				5
6			Woodley Manor	Montgomery				6
7			Excell Health Care Center	Oakland				7
8			Flagship Heath care Center	Newport Beach				8
9			Tarzana Health & Rehab Center	Tarzana				9
10			Diamond Ridge Health Care Center	Pittsburgh				10
11			Courtyard Care Center	San Jose				11
12			Mission Carmichael Health Care Center	Carmichael				12
13			AlpineLiving Center	Thornton				13
14			Boulder Manor	Boulder				14
15			Pearl Street Health Care Center	Englewood				15
16			Applewood Living Center	Longmont				16
17			Fort Collins Health Care Center	Fort Collins				17
18			Spring Creek Healthcare Center	Fort Collins				18
19			Berthoud Living Center	Berthoud				19
20			Sierra Vista Health Care Center	Loveland				20
21			Windsor Health Care Center	Windsor				21
22			San Juan Living Center	Montrose				22
23			Four Corners Health Care Center	Durango				23
24			Palisade Living Center	Palisade				24
25			Colonial Columns Nursing Center	Colorado Springs				25
26			Cedarwood Health Care Center	Colorado Springs				26
27			Minnequa Medicenter	Pueblo				27
28			Terrace Gaedens Healthcare Center	Colorado Springs				28
29			Aspen Living Cente	Colorado Springs				29
30			Belmont Lodge	Pueblo				30

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Centennial Heathcare Center	Greeley				1
2			Kenton Manor	Greeley				2
3			Stering Living Center	Sterling				3
4			Sunset Manor	Brush				4
5			Yuma Life Care Center	Yuma				5
6			Jewell Care Center of Denver	Denver				6
7			Monaco Parkway	Denver				7
8			Garden Square at Spring Creek	Fort Collins				8
9			Pendleton Health & Rehab	Mystic				9
10			Bride Brook Health & Rehab	Niantic				10
11			Brian Center Nursing Care Austell	Austll				11
12			Brian Center Health & Rehab Canton	Canton				12
13			Northeast Atlanta Healty & Rehab	Atlanta				13
14			Brighton Place West	Topeka				14
15			Indian Creek Healht Care Center	Overland Park				15
16			SE Massachusetts Health & Rehab	New Bedford				16
17			Methuen Health & Rehab Center	Methuen				17
18			Patuxent River Health & Rehab Center	Laurel				18
19			Arcola Heatlh & Rehab Center	Silver Spring				19
20			Glen Burnie Health & Rehab Center	Glen Burnie				20
21			Overlea Health & Rehab Center	Baltimore				21
22			Bethesda Health & Rehab Center	Bethesda				22
23			Summit Park Health & Rehab Center	Catonsville				23
24			North Arundel Health & Rehab Center	Glen Burnie				24
25			Bel Air Health & Rehab Center	Bel Air				25
26			Forest Hill Health & Rehab Center	Forest Hill				26
27			Heritage Harbour Health & Rehab Center	Annapolis				27
28			Cambridge East	Madison Heights				28
29			Cambridge North	Clawson				29
30			Cambridge South	Beverly Hills				30

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC		Clarkston	Clarkston				1
2			Clinton-Aire Healthcare Center	Clinton Township				2
3			Crestmont NursingCare Center	Fenton				3
4			Heritage Manor	Flint				4
5			Hope Health Care Center	Westland				5
6			Warren Woods Health Care Center	Warren				6
7			Superior Woods Health Care Center	Ypsilanti				7
8			Countrybrook Living Center	Brook Haven				8
9			Brian Center Health & Rehab Eden	Eden				9
10			Brian Center Nursing Care Lexington	Lexington				10
11			Brian Center Health & Rehab Hickory East	Hickory				11
12			Brian Center Health & Rehab Wilson	Wilson				12
13			Randolph Health & Rehab Center	Asheboro				13
14			Brian Center Health & Rehab Winston Salem	Winston Salem				14
15			Brian Center Health & RehabCharlotte	Charlotte				15
16			Brian Center Health & Rehab Windsor	Windsor				16
17			Maple Leaf Health Care	Statesville				17
18			Brian Center Health & Rehab Weaverville	Weaverville				18
19			Brian Center Health & Rehab Lincolnton	Lincolnton				19
20			Brian Center Health & Rehab Wallace	Wallace				20
21			Brian Center Health & Rehab Monroe	Monroe				21
22			Brian Center Health & RehabDurham	Durham				22
23			Brian Center Health & Rehab Goldsboro	Goldsboro				23
24			Brian Center Health & Rehab Cabarrus	Concord				24
25			Brian Center Nursing Care Shamrock	Charlotte				25
26			Brian Center Nursing Care Hickory	Hickory				26
27			Brian Center Health & Rehab Center Waynesvi	Waynesville				27
28			Brian Center Health & Rehab Clayton	Clayton				28
29			Brian Center Health & Rehab Brevard	Bervard				29
30			Brian Center Health & Rehab Yanceyville	Yanceyville				30

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Brian Center Health & Rehab Hertfort	Hertford				1
2			Brian Center Health & Rehab Spruce Pine	Spruce Pine				2
3			Brian Center Health & Rehab Hendersonville	Hendersonville				3
4			Brian Center Health & Rehab Salisbury	Salisbury				4
5			Mariner Health Care of Wilmington	Wilmington				5
6			Silver Stream Health & Rehab	Wilmington				6
7			Kenansville Health & Rehab	Kenansville				7
8			Charlotte Apts	Charlotte				8
9			Forest City Health & Rehab	Forest City				9
10			Arbor Manor Living Center	Fremont				10
11			Crete Manor	Crete				11
12			Haven Home	Kenesaw				12
13			Pawnee Manor	Pawnee City				13
14			Pierce Manor	Pierce				14
15			West Point Living Center	West Point				15
16			North Hills Health & Rehab	Wexford				16
17			West Hills Health & Rehab	Coraopolis				17
18			Broomall Health & Rehab	Broomall				18
19			Seneca Health & Rehab	Senaca				19
20			Sumter East Health & Rehab	Sumter				20
21			Golden Age Inman	Inman				21
22			Inman Healthcare	Inman				22
23			Lebanon Health & REhab	Lebanon				23
24			Greenhills Health & Rehab	Nashville				24
25			Norris Health & Rehab	Andersonville				25
26			Newport Health & Rehab	Newport				26
27			Cheyenne Healthcare	Cheyenne				27
28			Poplar Living Center	Casper				28
29			Sheridan Manor	Sheridan				29
30			Huntington Health Care	Huntington				30

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Bastrop Nursing Center	Bastrop				1
2			Care Inn of La Grange	La Grange				2
3			Kountze Nursing Center	Kountze				3
4			Retama Manor Nursing Center San Antonio No	San Antonio				4
5			Retama Manor Nursing Center San Antonio We	San Antonio				5
6			Retama Manor Nursing Center Alice	Alice				6
7			Retama Manor Nursing Center Edinburg	Edinburg				7
8			Retama Manor Nursing Center Harlingen	Harlingen				8
9			Retama Manor Nursing Center Jourdanton	Jourdanton				9
10			Retama Manor Nursing Center Laredo South	Laredo				10
11			Retama Manor Nursing Center Laredo West	Laredo				11
12			Retama Manor Nursing Center McAllen	McAllen				12
13			Retama Manor Nursing Center Pleasanton Nort	Pleasanton				13
14			Retama Manor Nursing Center Pleasanton Sout	Pleasanton				14
15			Retama Manor Nursing Center Rio Grande City	Rio Grande City				15
16			Retama Manor Nursing Center Robstown	Robstown				16
17			Retama Manor Nursing Center Weslaco	Weslaco				17
18			Weatherford health Care Center	Weatherford				18
19			Peach Tree Place	Weatherford				19
20			Retama Manor Nursing Center Raymondville	Raymondville				20
21			Memorial City Health and Rehab	Houston				21
22			Jacinto City Healthcare Center	Houston				22
23			Spring Branch Healthcare Center	Houston				23
24			Retama Manor Nursing Center Corpus Christi I	Corpus Christi				24
25			Downtown Health & Rehab	Fort Worth				25
26			Lakeshore Village Healthcare Center	Waco				26
27			Deer Creek of Wimberley	Wimberley				27
28			La Paloma Nursing Center	San Diego				28
29			Pine Arbor	Silsbee				29
30			Las Palmas Healthcare Center	McAllen				30

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Hilltop Village	Kerville				1
2			Silver Creek Manor	San Antonio				2
3			Alpine Terrace	Kerrville				3
4			Edgewater Care Center	Kerrville				4
5			Arlington Heights Health & Rehab	Fort Worth				5
6			The Meadows Health & Rehab	Dallas				6
7			Northgate Health & Rehab	San Antonio				7
8			Interlochen Health & Rehab	Arlington				8
9			First Colony Health & Rehab	Missouri City				9
10			Cypresswood Health & Rehab	Houston				10
11			Northwest Health & Rehab	Houston				11
12			The Westbury Place	Houston				12
13			Westchase Health & Rehab	Houston				13
14			Woodwind Lakes Health & Rehab	Houston				14
15			Pasadena Care Center	Pasadena				15
16			Bay Villa	Bay City				16
17			Alice Health care Center	Alice				17
18			Bangs Nursing Home	Bangs				18
19			Brazosview	Richmond				19
20			Courtyards at Fort Worth	Fort Worth				20
21			Faith Memorial	Pasadena				21
22			Golden Years	Marlin				22
23			Greenview Manor	Waco				23
24			Hillview Health & Rehab	Goldthwaite				24
25			Levelland Health Care	Levelland				25
26			Longmeadow Health Care	Justin				26
27			Memorial Medical Nursing Center	San Antonio				27
28			Mount Pleasant	Mount Pleasant				28
29			North Park Health & Rehab	McKinney				29
30			Pampa Health Care Center	Pampa				30

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Park Highlands Health Care Center	Athens				1
2			Pleasant Springs Health Care Center	Mount Pleasant				2
3			Sweeny Health Care Center	Sweeny				3
4			Texoma Health Care Center	Sherman				4
5			The Park in Plano	Plano				5
6			Ashland Health & Rehab	Ashland				6
7			Southpointe Health Care Center	Greenfield				7
8			Virginia Highlands Health & Rehab Center	Germantown				8
9			Grande Prairie Health & Rehab Center	Pleasant Prairie				9
10			Pleasant Valley Health Care Center	Derry				10
11			The Village at Alameda	Albuquerque				11
12			Hobbs Healthcare Center	Hobbs				12
13			Lake Mead Health Care Center	Henderson				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 2/31/2014

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				$	$		$ 73	1
2	6	Repair and Maintenance							37,391	2
3	19	Professional Services							13,805	3
4	20	Fee, Subscriptions and Promos							18,065	4
5	10	Nursing & Medical Records							439,734	5
6	21	Clerical & Gen Office Exp							3,681	6
7	24	Travel & Seminar							71,023	7
8	26	Insurance							8,973	8
9	36	Drpreiation							72,503	9
10	17	Communications							11,106	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense							38,933	12
13	22	Payroll Taxes							55,619	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					$	$		$ 770,906	25

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 299,075	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.)		$ 308,541	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,466	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 345,444	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.		$ 354,910	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	242,745	8
2010	242,041	9
2011	242,052	10
2012	283,745	11
2013	308,541	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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	$ 308,541.00	$ 308,541.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 308,541.00	$ 308,541.00

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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	1975	$	$		$	$	$	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		6,106	9
10	Concrete Sidewalk 1/3 downpayment			2005	1,628	143	12	143		1,355	10
11	12.5 Ton RTU - Kitchen - Balance			2005	6,484	648	10	648		6,052	11
12	Concrete Sidewalk			2005	3,389		11.5			1,999	12
13	Plumbing Project			2005	4,750	413	11.8	413		3,958	13
14	Plumbing Repairs			2005	10,000	870	11.8	870		8,333	14
15	Instl Door w/Closer - Exit Device			2005	2,576	231	11.5	231		2,134	15
16	Mixing Valve Spout - Kitchen			2005	2,207	198	11.5	198		1,828	16
17	Dry Sprinkler System Repair			2005	2,159	193	11.5	193		1,788	17
18	Repair Dry Sprinkler System			2005	1,893	169	11.5	169		1,568	18
19	Heat Pump			2005	1,255	112	11.5	112		1,039	19
20	Double Swing Gates - Dumpster			2005	1,226		8			1,226	20
21	Heat - Shower Room			2005	19,832	1,983	10	1,983		18,345	21
22	Remove Carpet and Install Tile			2005	37,384	3,738	10	3,738		33,959	22
23											23
24	Emergency Generator			2006	2,907		11.25			1,679	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		6,232	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	666	10.5	666		5,773	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: 01/01/2014 Ending: 12/31/2014

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		1,556	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			6,701	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	53	10.25	53		448	48
49	Crash Rails for Walls	2006	2,961	282	10.42	282		2,421	49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269	27	10	27		220	51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21	2	10	2		17	52
53	Carpet/Labor	2007	4,440		5			4,440	53
54	Front Automatic Doors - Balance	2007	7,122	712	10	712		6,113	54
55	10: Overbed Lights	2007	1,689	169	10	169		1,407	55
56	Use Tax - 10: Overbed Lights	2007	131	13	10	13		109	56
57	59: Wall Boxes/Sconce Lights	2007	1,675	167	10	167		1,396	57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127	13	10	13		106	58
59	Remodel North & South Front Exit	2007	1,049	107	9.75	107		845	59
60	Heat/Cool Unit	2007	959	97	9.83	97		774	60
61	Connect Kit Heat/AC Unit	2007	46	5	9.83	5		37	61
62	Repair to Walk In Freezer	2007	5,177	518	9.92	518		4,185	62
63	Fire Sprinkler Repair	2007	2,826	283	9.92	283		2,284	63
64	Design Fee	2007	2,900	285	10.08	285		2,353	64
65	Design Fee	2007	225	22	10.08	22		182	65
66	50 Overbed Lights and Wall Sconces	2007	8,572	836	10.16	836		6,970	66
67	50 Overbed Lights and Wall Sconces	2007	664	65	10.16	65		540	67
68	61 Mount Wall Box Sconces	2007	1,741	174	9.92	174		1,407	68
69	61 Mount Wall Box Sconces	2007	135	13	9.92	13		109	69
70	TOTAL (lines 4 thru 69)		$ 210,809	$ 14,745		$ 14,745	$	$ 188,699	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: 01/01/2014 Ending: 12/31/2014

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	$ 14,745		$ 14,745	$	$ 188,699	1
2	29 Oxygen Concentrators	2007	15,536	1,580	9.75	1,580		12,507	2
3	29 Oxygen Concentrators	2007	1,204	122	9.75	122		969	3
4	Cr: Void Ck Village Westchester	2007	(1,049)	(107)	9.75	(107)		(845)	4
5	Permit Fee to Remode;	2007	1,049	108	9.66	108		843	5
6	Connection Kit Heat/Cool Unit	2007	46	5	9.83	5		37	6
7	2 Connect Kits Heat/AC Units	2007	92	9	9.83	9		74	7
8	Cr on Heat/AC Unit	2007	(891)	(91)	9.75	(91)		(717)	8
9	4 Heat/Cool Units	2007	3,564	359	9.83	359		2,875	9
10	4 Power Conn Kits Heat/AC Units	2007	201	20	9.83	20		162	10
11	Furnace Repair	2007	1,380	139	9.83	139		1,114	11
12	Heat Repair	2007	3,033	303	10	303		2,730	12
13	Repair 8 Heat AC Units	2007	11,700	1,171	10	1,171		10,530	13
14	Boiler Repair	2007	661	67	9.75	67		532	14
15	Remodel North/Southwest Exits	2007	53,930	5,579	9.58	5,579		43,237	15
16	AC Unit	2007	4,835	483	10	483		4,029	16
17	AC Unit	2007	375	37	10	37		312	17
18	Water Heater	2007	1,866	190	9.75	190		1,502	18
19	Stainless Steel End Wall Kitchen	2007	1,261	133	9.41	133		1,007	19
20									20
21	2:AC Compressor Units	2008	9,874	1,059	9.25	1,059		7,846	21
22	Steel Door	2008	1,675	184	9	184		1,322	22
23	Furnace 50% Deposit	2008	2,759	312	8.75	312		2,160	23
24	Compressor For Cooling System	2008	3,993	424	9.33	424		3,180	24
25	Furnace -Final Payment	2008	2,759	315	8.66	315		2,154	25
26	Steel Door - Balance	2008	1,675	190	8.75	190		1,312	26
27	2: Zoneline Heat/Cool Units	2008	1,341	153	8.66	153		1,048	27
28	Heat Exchanger for Boiler	2008	7,510	867	8.58	867		5,849	28
29	6: Zoneline heat/Cool Units	2008	3,636		5			3,636	29
30	AT&T Circuit Conversion	2008	32,788	3,975	8.16	3,975		25,171	30
31	AT&T Circuit Conversion	2008	6,306	780	8	780		4,811	31
32	Blower Assembly	2008	3,511	434	8	434		2,679	32
33									33
34	TOTAL (lines 1 thru 33)		$ 387,429	$ 33,545		$ 33,545	$	$ 330,765	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: 01/01/2014 Ending: 12/31/2014

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	$ 33,545		$ 33,545	$	$ 330,765	1
2	3: Zoneline Heat/Cool Units	2009	1,999	267	7.42	267		1,488	2
3	Condenser fan motor	2009	8,348	1,101	7.5	1,101		6,238	3
4	2: Zoneline Heat/Cool Units	2009	1,333	180	7.34	180		988	4
5	Front Entry Paint	2009	6,241	624	5	624		6,241	5
6	Replace Gaas Valve & Thermometer	2009	2,500	353	7	353		1,823	6
7									7
8	2: Zoneline Heat/Cool Units	2010	1,346	190	7	190		982	8
9	Wanderguard	2010	2,744	383	7	383		2,010	9
10	Attic Sprikler System	2010	33,760	5,065	6.66	5,065		24,055	10
11	Replaced Heat Exchanger	2010	8,224	1,175	6.92	1,175		5,972	11
12	Rplc Furnace Thermostate & Sensor	2010	2,512	359	6.92	359		1,824	12
13	Zoneline Heat/Cool Unit	2010	568	114	5	114		559	13
14	3: Zoneline Heat/Cool Units	2010	1,968	288	6.75	288		1,416	14
15	Attic Sprikler System	2010	52,686	7,903	0.92	7,903		37,539	15
16	Attic Sprikler System	2010	47,056	7,058	6.92	7,058		33,529	16
17	Rplc Bearing Assembly & Blower Motor	2010	6,357	919	6.83	919		4,595	17
18	Attic Sprikler System	2010	8,025	1,219	6.92	1,219		5,790	18
19	Site Survey	2010	225	36	6.16	36		156	19
20	Compressor Unit	2010	3,102	490	6.16	490		2,163	20
21	Rplc Water Heater	2010	10,077	1,592	6.25	1,592		7,027	21
22	Replace Tempering Valves	2010	4,740	769	6.08	769		3,267	22
23									23
24	Maglock	2011	798	124	6.34	124		560	24
25	3: Zoneline Heat/Cool Units	2011	2,202	440	6	440		1,762	25
26	Facility Building Sign	2011	2,203	389	6.5	389		1,425	26
27									27
28	Dry Pendant Sprinkler Heads	2012	5,598	1,101	5	1,101		3,396	28
29	3: Zoneline Heat/Cool Units	2012	2,343	485	5	485		1,373	29
30	Garbage Disposal	2012	756	168	5	168		420	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 605,140	$ 66,337		$ 66,337	$	$ 487,363	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: 01/01/2014 Ending: 12/31/2014

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	$ 66,337		$ 66,337	$	$ 487,363	1
2	Mixing Valves	2013	5,790	1,478	44	1,478		2,834	2
3	Heat Draft Inducer Motor	2013	4,043	1,032	4	1,032		1,979	3
4	Aluminum Light Pole	2013	3,200	784	4	784		1,633	4
5	Inducer	2013	3,571	912	3.75	912		1,748	5
6	5: Duct Detectors	2013	3,035	809	3.75	809		1,416	6
7	Inducer - Credit Memo	2013	(689)	(180)	3.83	(180)		(330)	7
8	A/C Motor Kitchen Area	2013	1,642	438	3.75	438		766	8
9	Relays for Duct Smoke Detector	2013	1,000	273	3.67	273		455	9
10	19: Damper Actuators	2013	4,370	1,221	3.58	1,221		1,932	10
11	12: Damper Actuators	2013	1,338	373	3.58	373		591	11
12	Generator Transfer Switch	2013	4,722	1,318	3.58	1,318		2,086	12
13	12 Damper Actuators	2013	1,338	373	3.58	373		591	13
14	A/C Compressor Unit #1	2013	3,668	1,048	3.5	1,048		1,572	14
15	A/C Compressor & Condenser Fan	2013	3,580	1,048	3.42	1,048		1,484	15
16	Hot Water Booster Heater - Dishwasher	2013	2,529	740	3.42	740		1,048	16
17	7: Exhaust Vents	2013	1,332	410	3.25	410		512	17
18	Motor for Unit #8	2013	2,268	698	3.25	698		872	18
19	Bearing Assembly Water Heater	2013	2,960	911	3.25	911		1,138	19
20	Gas Valve and Ignition Control	2013	2,294	724	3.17	724		845	20
21									21
22	PTAC Unit	2014	847	282	3	282		282	22
23	PTAC Unit	2014	847	282	3	282		282	23
24	A/C Heating Units 9A & 9B	2014	14,770	4,344	3	4,344		4,344	24
25	3: Exhaust Fan Motors	2014	3,235	249	9.75	249		249	25
26	Condesning Unit for # 3 A/C	2014	3,157	132	12	132		132	26
27	Mixing Valve Cartridge	2014	1,766	74	12	74		74	27
28	Split A/C System- Laudry & Hall	2014	2,535	127	10	127		127	28
29	Condesner for Walkin Freezer	2014	14,370	599	10	599		599	29
30	Door Closer & Hing System	2014	7,790	274	11.83	274		274	30
31	10: LCN 4040 24v Door Holder	2014	3,074	87	11.83	87		87	31
32	11: Aluminum 24 LCN Closer Door	2014	7,329	366	10	366		366	32
33			7,376	106	11.58	106		106	33
34	TOTAL (lines 1 thru 33)		$ 724,227	$ 87,669		$ 87,669	$	$ 517,457	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: 01/01/2014 Ending: 12/31/2014

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	$ 461,416	$ 53,355	$ 53,355	$		$ 331,361	71
72	Current Year Purchases	32,113	7,158	7,158			7,158	72
73	Fully Depreciated Assets	(38,814)						73
74								74
75	TOTALS	$ 454,715	$ 60,513	$ 60,513	$		$ 338,519	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)	$ 1,178,942	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,182	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 148,182	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)	$ 855,976	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: 01/01/2014 Ending: 12/31/2014

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? ☐ YES ☐ NO
   If NO, see instructions.

		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	10/11/2013	$ 942,751	12		3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 942,751 **			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 06/02/2014
    Ending 05/31/2026

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$ 891,161
13.	/2016	$ 908,984
14.	/2017	$ 936,254

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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	3784	hrs	$ 162,949		$	$	3,784	$ 162,949	1
2	Licensed Speech and Language Development Therapist	10a-03	2001	hrs	91,373				2,001	91,373	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	5770	hrs	244,166				5,770	244,166	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				126,919		126,919	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				$ 498,488		$	$ 126,919	11,555	$ 625,407	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: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	240,280		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,643,288		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,510		6
7	Other Prepaid Expenses	29,237		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,914,615	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	272,348		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	724,227		15
16	Equipment, at Historical Cost	454,715		16
17	Accumulated Depreciation (book methods)	(855,904)		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):	19,354		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 614,740	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,529,355	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 256,178	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	909,039		30
31	Accrued Taxes Payable (excluding real estate taxes)	(225)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	381,987		32
33	Accrued Interest Payable			33
34	Deferred Compensation	34,317		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accruals	93,456		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,674,752	$	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	CLO & Intercompany	2,219,735		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,219,735	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,894,487	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,365,132)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,529,355	$	48

***(See instructions.)**

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (867,348)	1	
2	Restatements (describe):	(817,039)	2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,684,387)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	319,255	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)**	$ 319,255	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)**	$ (1,365,132)	24	*

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 8,827,387	1
2	Discounts and Allowances for all Levels	(1,361,511)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,465,876	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,247,799	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,247,799	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	12,404	13
14	Non-Patient Meals	109	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	323,361	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,768	19
20	Radiology and X-Ray	17,588	20
21	Other Medical Services	4,437	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 380,667	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	Miscellaneous Receipts	1,722	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,722	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,096,064	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,320,658	31
32	Health Care	3,559,989	32
33	General Administration	1,903,145	33
	B. Capital Expense		
34	Ownership	1,529,978	34
	C. Ancillary Expense		
35	Special Cost Centers	175,403	35
36	Provider Participation Fee	287,636	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,776,809	40
41	**Income before Income Taxes (line 30 minus line 40)****	319,255	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 319,255	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,888,091	44
45	Private Pay - Net Inpatient Revenue	966,617	45
46	Medicare - Net Inpatient Revenue	1,240,791	46
47	Other-(specify) HMO/Ins	36,776	47
48	Other-(specify) VA/Hospice	333,601	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,465,876	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,899	2,091	$ 89,123	$ 42.62	1
2	Assistant Director of Nursing	1,048	1,088	42,788	39.33	2
3	Registered Nurses	8,074	8,735	292,572	33.49	3
4	Licensed Practical Nurses	35,876	38,999	1,009,324	25.88	4
5	CNAs & Orderlies	72,123	77,267	1,011,868	13.10	5
6	CNA Trainees					6
7	Licensed Therapist	10,798	11,555	498,488	43.14	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,025	2,187	49,187	22.49	9
10	Activity Assistants	2,009	2,200	25,541	11.61	10
11	Social Service Workers	3,672	4,043	90,308	22.34	11
12	Dietician					12
13	Food Service Supervisor	1,725	2,132	49,427	23.18	13
14	Head Cook	6,231	6,799	102,724	15.11	14
15	Cook Helpers/Assistants	13,081	14,508	120,239	8.29	15
16	Dishwashers					16
17	Maintenance Workers	1,987	2,091	47,546	22.74	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,971	2,091	102,220	48.89	20
21	Assistant Administrator					21
22	Other Administrative	4,389	4,972	161,449	32.47	22
23	Office Manager					23
24	Clerical	3,503	3,729	54,818	14.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,363	1,363	20,938	15.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,774	185,850	$ 3,768,560 *	$ 20.28	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		$ 68,118	1-3	35
36	Medical Director		16,800	9-3	36
37	Medical Records Consultant		4,304		37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,386	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		744	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		18,921	11-3	44
45	Social Service Consultant			12-3	45
46	Other(specify) Admin		58,582	10-3	46
47	X/Ray & Lab		29,791	39-3	47
48	Dentist/Physician/Psychiatrist		1,888	39-3	48
49	TOTAL (lines 35 - 48)		$ 209,534		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Martin T Lee	Administrator		$ 102,220
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,220

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	$ 602
Cass Information Systems	Litigation Tracking	1,488
Illnois State Police Cook Co Clerk	Background Checks	3,853
My Innerview/Laminex/Equifax	Resident Survey	157
Legal	Legal	31,809
TALX	Unemployment Tracking	577
LexisNexis	Risk Data Service	232
National Research	Quality Care Analysis	1,021
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 39,739

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,365
Unemployment Compensation Insurance	118,180
FICA Taxes	275,016
Employee Health Insurance	151,832
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,346
Other Benefits	8,054
Home Office Payroll Taxes	55,619
TOTAL (agree to Schedule V, line 22, col.8)	$ 728,412

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,200
Health Care Worker Background Check	3,646
(Indicate # of checks performed)	
Patient Background Checks	
Publications and Manuals	19,038
Professional Dues	9,934
Other Licenses	2,964
Less: Public Relations Expense	( )
Non-allowable advertising	7,840
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,622

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 660
In-State Travel	1,310
Seminar Expense	4,656
Home Office Allocation	71,023
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 77,649

**See instructions.

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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 Association $ 9784**

(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. $ **52,551** 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? **X** YES _____ 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. $ **287,636**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.