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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0052522

Facility Name: Brentwood Sub Acute HC Ctr

Address: 5400 West 87th St (Number) Burbank (City) 60459 (Zip Code)

County: Cook

Telephone Number: 708 423-1200 **Fax #** 708 423-8405

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2014

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 01/01/2015 to 12/31/2015 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) Senior 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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	163	Skilled (SNF)	163	59,495	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	163	TOTALS	163	59,495	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	3,458	2,677	23,638	29,773	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,458	2,677	23,638	29,773	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.04%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 163 and days of care provided 13,458

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	787	792	530,841	532,420		532,420	(213,770)	318,650			1
2	Food Purchase		2,609		2,609		2,609	213,674	216,283			2
3	Housekeeping		25,444	296,075	321,519		321,519		321,519			3
4	Laundry		8,538	172,464	181,002		181,002		181,002			4
5	Heat and Other Utilities			181,836	181,836		181,836	(1,227)	180,609			5
6	Maintenance	82,212	317,204	24,409	423,825		423,825	55,232	479,057			6
7	Other (specify):*			53,954	53,954		53,954		53,954			7
8	**TOTAL General Services**	82,999	354,587	1,259,579	1,697,165		1,697,165	53,909	1,751,074			8
	B. Health Care and Programs											
9	Medical Director			78,000	78,000		78,000		78,000			9
10	Nursing and Medical Records	3,661,797	496,068	121,390	4,279,255		4,279,255	552,305	4,831,560			10
10a	Therapy	563,801	636,081	2,017,162	3,217,044		3,217,044		3,217,044			10a
11	Activities	61,326	3,183	4,072	68,581		68,581		68,581			11
12	Social Services	174,660	25		174,685		174,685		174,685			12
13	CNA Training											13
14	Program Transportation		41	(24,818)	(24,777)		(24,777)		(24,777)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,461,584	1,135,398	2,195,806	7,792,788		7,792,788	552,305	8,345,093			16
	C. General Administration											
17	Administrative	120,068			120,068		120,068	9,327	129,395			17
18	Directors Fees			591	591		591		591			18
19	Professional Services			69,539	69,539		69,539	(14,060)	55,479			19
20	Dues, Fees, Subscriptions & Promotions			60,567	60,567		60,567	1,914	62,481			20
21	Clerical & General Office Expenses	376,639	24,640	1,043,495	1,444,774		1,444,774	(983,962)	460,812			21
22	Employee Benefits & Payroll Taxes			752,555	752,555		752,555	78,179	830,734			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,170	19,170		19,170	58,470	77,640			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,021,609	1,021,609		1,021,609	(967,278)	54,331			26
27	Other (specify):* Franchise Tax							300	300			27
28	**TOTAL General Administration**	496,707	24,640	2,967,526	3,488,873		3,488,873	(1,817,110)	1,671,763			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,041,290	1,514,625	6,422,911	12,978,826		12,978,826	(1,210,896)	11,767,930			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 Brentwood Sub Acute HC Ctr #0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			158,890	158,890		158,890	(35,799)	123,091			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			550,575	550,575		550,575	60,865	611,440			32
33	Real Estate Taxes			1,219,523	1,219,523		1,219,523	234,135	1,453,658			33
34	Rent-Facility & Grounds			630,186	630,186		630,186		630,186			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							85,113	85,113			36
37	TOTAL Ownership			2,559,174	2,559,174		2,559,174	344,314	2,903,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		777,581	372,442	1,150,023		1,150,023		1,150,023			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			188,276	188,276		188,276		188,276			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		777,581	560,718	1,338,299		1,338,299		1,338,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,041,290	2,292,206	9,542,803	16,876,299		16,876,299	(866,582)	16,009,717			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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(1,312)	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	(96)	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	(3,608)	21		18
19	Entertainment	(395)	24		19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(59,778)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(200,662)	21		24
25	Fund Raising, Advertising and Promotional	(86,155)	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	(1,489,386)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,841,392)		$	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)	969,867		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 969,867		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (871,525)		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**

Brentwood Sub Acute HC Ctr

ID# **0052522**

Report Period Beginning: **01/01/2015**

Ending: **12/31/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Rent Averaging	$	34	1
2	Reclass Franchise Tax to Line 27	(300)	33	2
3	Reclass Franchise Tax to Line 27	300	27	3
4	Real Estate Accrual Adjustment	234,435	33	4
5	Back Office Service Fee	(699,658)	21	5
6	Professional Liability Insruance Adjustment	(983,421)	26	6
7	Depreciation Adjustment	(35,799)	30	7
8	Reclass Raw Food	(213,770)	1	8
9	Reclass Raw Food	213,770	2	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**	(1,484,443)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	(213,770)	0	0	0	0	0	0	0	0	0	0	(213,770)	1
2	Food Purchase	213,674	0	0	0	0	0	0	0	0	0	0	213,674	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	(1,312)	85	0	0	0	0	0	0	0	0	0	(1,227)	5
6	Maintenance	0	55,232	0	0	0	0	0	0	0	0	0	55,232	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,408)	55,317	0	0	0	0	0	0	0	0	0	53,909	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	552,305	0	0	0	0	0	0	0	0	0	552,305	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	552,305	0	0	0	0	0	0	0	0	0	552,305	16
	C. General Administration													
17	Administrative	0	9,327	0	0	0	0	0	0	0	0	0	9,327	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(59,778)	45,718	0	0	0	0	0	0	0	0	0	(14,060)	19
20	Fees, Subscriptions & Promotions	0	1,914	0	0	0	0	0	0	0	0	0	1,914	20
21	Clerical & General Office Expenses	(990,083)	6,121	0	0	0	0	0	0	0	0	0	(983,962)	21
22	Employee Benefits & Payroll Taxes	0	78,179	0	0	0	0	0	0	0	0	0	78,179	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(395)	58,865	0	0	0	0	0	0	0	0	0	58,470	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(983,421)	16,143	0	0	0	0	0	0	0	0	0	(967,278)	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	**TOTAL General Administration**	(2,033,377)	216,267	0	0	0	0	0	0	0	0	0	(1,817,110)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,034,785)	823,889	0	0	0	0	0	0	0	0	0	(1,210,896)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	(35,799)	0	0	0	0	0	0	0	0	0	0	(35,799)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	60,865	0	0	0	0	0	0	0	0	0	60,865	32
33	Real Estate Taxes	234,135	0	0	0	0	0	0	0	0	0	0	234,135	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	85,113	0	0	0	0	0	0	0	0	0	85,113	36
37	**TOTAL Ownership**	198,336	145,978	0	0	0	0	0	0	0	0	0	344,314	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)**	(1,836,449)	969,867	0	0	0	0	0	0	0	0	0	(866,582)	45

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	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 Care Center	Westchester			
		Brentwood Sub Acute Health Care 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%	$ 85	$ 85	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	55,232	55,232	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	45,718	45,718	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	1,914	1,914	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	552,305	552,305	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	6,121	6,121	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	58,865	58,865	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	16,143	16,143	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	85,113	85,113	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	9,327	9,327	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%	60,865	60,865	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	78,179	78,179	13
14	Total			$			$ 969,867	$ * 969,867	14

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

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Busine
1	SSC Equity Holding Company LLC	100	Clarkston	Clarkston			
2			Clinton-Aire Healthcare Center	Clinton Township			
3			Crestmont NursingCare Center	Fenton			
4			Heritage Manor	Flint			
5			Hope Health Care Center	Westland			
6			Warren Woods Health Care Center	Warren			
7			Superior Woods Health Care Center	Ypsilanti			
8			Countrybrook Living Center	Brook Haven			
9			Brian Center Health & Rehab Eden	Eden			
10			Brian Center Nursing Care Lexington	Lexington			
11			Brian Center Health & Rehab Hickory East	Hickory			
12			Brian Center Health & Rehab Wilson	Wilson			
13			Randolph Health & Rehab Center	Asheboro			
14			Brian Center Health & Rehab Winston Salem	Winston Salem			
15			Brian Center Health & RehabCharlotte	Charlotte			
16			Brian Center Health & Rehab Windsor	Windsor			
17			Maple Leaf Health Care	Statesville			
18			Brian Center Health & Rehab Weaverville	Weaverville			
19			Brian Center Health & Rehab Lincolnton	Lincolnton			
20			Brian Center Health & Rehab Wallace	Wallace			
21			Brian Center Health & Rehab Monroe	Monroe			
22			Brian Center Health & RehabDurham	Durham			
23			Brian Center Health & Rehab Goldsboro	Goldsboro			
24			Brian Center Health & Rehab Cabarrus	Concord			
25			Brian Center Nursing Care Shamrock	Charlotte			
26			Brian Center Nursing Care Hickory	Hickory			
27			Brian Center Health & Rehab Center Waynesvi	Waynesville			
28			Brian Center Health & Rehab Clayton	Clayton			
29			Brian Center Health & Rehab Brevard	Bervard			
30			Brian Center Health & Rehab Yanceyville	Yanceyville			

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Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Busine
1	SSC Equity Holding Company LLC	100	Park Highlands Health Care Center	Athens			
2			Pleasant Springs Health Care Center	Mount Pleasant			
3			Sweeny Health Care Center	Sweeny			
4			Texoma Health Care Center	Sherman			
5			The Park in Plano	Plano			
6			Ashland Health & Rehab	Ashland			
7			Southpointe Health Care Center	Greenfield			
8			Virginia Highlands Health & Rehab Center	Germantown			
9			Grande Prairie Health & Rehab Center	Pleasant Prairie			
10			Pleasant Valley Health Care Center	Derry			
11			The Village at Alameda	Albuquerque			
12			Hobbs Healthcare Center	Hobbs			
13			Lake Mead Health Care Center	Henderson			
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Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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: (832-467-6982

	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				$ 85	$		$	1
2	6	Repair and Maintenance				55,232				2
3	19	Professional Services				45,718				3
4	20	Fee, Subscriptions and Promos				1,914				4
5	10	Nursing & Medical Records				552,305				5
6	21	Clerical & Gen Office Exp				6,121				6
7	24	Travel & Seminar				58,865				7
8	26	Insurance				16,143				8
9	36	Drpreiation				85,113				9
10	17	Communications				9,327				10
11	35	Rental and Lease								11
12	32	Interest Income/Expense				60,865				12
13	22	Payroll Taxes				78,179				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					$ 969,867	$		$	25

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 787,031	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.)		$ 1,021,466	2
3. Under or (over) accrual (line 2 minus line 1).		$ 234,435	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 1,218,922	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.		$ 1,453,357	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011		9
2012		10
2013	845,259	11
2014	1,016,523	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brentwood Sub Acute HC Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052522

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE (832) 467-6317 FAX #: (832) 467-6982

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19333130080000	5400 West 87th St Bubank, IL	$ 128,418.93	$ 128,418.93
2.	19333130100000	5400 West 87th St Bubank, IL	$ 753,968.39	$ 753,968.39
3.	19333130140000	5400 West 87th St Bubank, IL	$ 4,942.93	$ 4,942.93
4.	19333230140000	5400 West 87th St Bubank, IL	$ 6,667.68	$ 6,667.68
5.	19333230150000	5400 West 87th St Bubank, IL	$ 17,112.27	$ 17,112.27
6.	19333130170000	5400 West 87th St Bubank, IL	$ 110,356.15	$ 110,356.15
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,021,466.35	$ 1,021,466.35

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,476 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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	163		2014		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Heat Exchanger RTU #18			2014	3,568	1,189	3	1,189		2,378	9
10	Water Heater 2nd Floor			2014	12,550	4,303	3	4,303		8,247	10
11	Polycom Phone			2014	521	169	3	169		352	11
12	Recirculation Pump on Boiler			2014	1,835	629	3	629		1,206	12
13	2: Vestibule Heaters			2014	4,827	1,704	3	1,704		3,123	13
14	Door Controller			2014	972	343	3	343		629	14
15	Water Heater - Laundry			2014	12,550	4,706	2.67	4,706		7,844	15
16	Damper Motor			2014	2,803	1,121	2.5	1,121		1,682	16
17	Chain Link Fence			2014	12,208	5,052	2.5	5,052		7,156	17
18	2 Metal Doors Installed			2014	4,890	2,096	2.33	2,096		2,794	18
19	Backflow Preventers			2014	5,824	2,184	2.67	2,184		3,640	19
20	Asphalt - Sawcut, Remove & Patch			2014	3,498	1,555	2.25	1,555		2,332	20
21	Motor, Fan for A/C Unit			2014	4,667	400	11.67	400		500	21
22	Pipes and Valves			2014	6,107	611	10	611		763	22
23	Hollow Metal Door w/Window			2014	1,553	621	2.5	621		932	23
24	Chiller & Unit for Gym			2014	5,013	430	11.67	430		537	24
25	Replaced Freezer Door			2014	4,940	426	11.58	426		498	25
26	Replaced AC Control Kit			2014	2,440	244	10	244		264	26
27											27
28	F1000-08 Wall Cabinet Fan Coil			2015	4,245	372	11.4	372		372	28
29	Install 3 Mortise Locks			2015	3,095	1,769	2.33	1,769		1,769	29
30	Install Pump			2015	4,571	457	10	457		457	30
31	Installed Inducer Motor			2015	1,764	154	11.4	154		154	31
32	Commercial Disposal			2015	2,055	411	5	411		411	32
33	Pleat Valance			2015	1,104	202	5	202		202	33
34	Manifold Replacement			2015	4,016	325	11.33	325		325	34
35	APC Smart Ups			2015	1,139	104	10	104		104	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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	APC Smart Ups	2015	$ 680	$ 62	10	$ 62	$	$ 62	37
38	Phone System	2015	234	21	10	21		21	38
39	CMBS Roof Replacement	2015	192,000	16,000	10	16,000		16,000	39
40	Analog Gateway	2015	4,472	373	10	373		373	40
41	Vacuum Compressor	2015	18,608	1,505	11.3	1,505		1,505	41
42	Booster Heather Kit	2015	2,200	165	10	165		165	42
43	Replaced Dryer in Cooler	2015	2,061	138	11.17	138		138	43
44	A/C Unit	2015	8,622	575	10	575		575	44
45	Landscaping Survey	2015	10,582	705	10	705		705	45
46	Landscaping Survey	2015	2,324	155	10	155		155	46
47	Installed Vacuum Compressr	2015	9,985	601	11	601		601	47
48	CMBS Roof Replacement	2015	195,840	11,424	10	11,424		11,424	48
49	Water Heater	2015	1,314	77	10	77		77	49
50	Asphalt Pavement	2015	27,625	2,014	8	2,014		2,014	50
51	CMBS Installed TPC Duct Work	2015	40,597	2,368	10	2,368		2,368	51
52	CMS Piping	2015	18,944	1,005	11	1,005		1,005	52
53	Compressor - Rooftop Chiller	2015	18,032	1,052	10	1,052		1,052	53
54	Wooden Door	2015	1,618	97	11	97		97	54
55	CMPS Asphalt Pavement	2015	27,625	1,439	8	1,439		1,439	55
56	CMBS Installed TPC Duct Work	2015	(40,597)	(1,692)	10	(1,692)		(1,692)	56
57	Replaced Fire Rated Door	2015	3,017	94	10.75	94		94	57
58	AASTRA: 68671 I Phone	2015	7,234	301	10	301		301	58
59	Water Control Valve	2015	29,002	1,538	11	1,538		1,538	59
60	Chiller and Air Handler	2015	2,061	1,288	2.67	1,288		1,288	60
61	Replaced Circulating Pump	2015	2,863	24	10	24		24	61
62	Pressure Control Tansducer	2015	2,792	23	10	23		23	62
63	Circulating Pump	2015	4,588	421	10	421		421	63
64	Chiller Pump Replace	2015	6,643	304	11	304		304	64
65	Valve Seal Kit	2015	1,805	1,083	2.5	1,083		1,083	65
66	Vacuum Vane	2015	2,837	1,836	2.83	1,836		1,836	66
67	Kitchen Hood Motor	2015	2,360	197	10	197		197	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 720,723	$ 76,771		$ 76,771	$	$ 93,864	70

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

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 119,793	$ 40,383	$ 40,383	$		$ 76,906	71
72	Current Year Purchases	77,967	5,937	5,937			5,937	72
73	Fully Depreciated Assets	(13,102)						73
74								74
75	TOTALS	$ 184,658	$ 46,320	$ 46,320	$		$ 82,843	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)	$ 905,381	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,091	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,091	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)	$ 176,707	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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SWC Property HoldingsLLC
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:	1962	163	01/01/2014	$ 13,860	3	5	3
4	Additions	1985						4
5		2002						5
6								6
7	TOTAL		163		$ 13,860 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 616,326
   This amount was calculated by dividing the total amount to be amortized 7,603,718
   by the length of the lease 12 .

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning 01/01/2014
    Ending 12/31/2026

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$ 1,248,612
13.	/2017	$
14.	/2018	$

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	hrs	$		$ 817,857	$		$ 817,857	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			229,733			229,733	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	hrs			969,572			969,572	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				777,581		777,581	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			$		$ 2,017,162	$ 777,581		$ 2,794,743	14

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

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	138,524		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,549,361		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,935		6
7	Other Prepaid Expenses	183,135		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,875,255	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,464		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	8,199,699		15
16	Equipment, at Historical Cost	190,336		16
17	Accumulated Depreciation (book methods)	(983,214)		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):	12,674		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,427,959	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,303,214	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 839,915	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	490,230		30
31	Accrued Taxes Payable (excluding real estate taxes)	(10)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,130,502		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accruals	59,107		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,519,744	$	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	12,610,069		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,610,069	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,129,813	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,835,157)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,294,656	$	48

***(See instructions.)**

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,410,907)	1
2	Restatements (describe):	(520,152)	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,931,059)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,904,098)	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)**	$ (2,904,098)	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)**	$ (4,835,157)	24 *

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

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 17,680,945	1
2	Discounts and Allowances for all Levels	(17,282,382)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 398,563	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	12,162,827	6
7	Oxygen	60	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 12,162,887	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,108,804	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	270,728	19
20	Radiology and X-Ray	26,002	20
21	Other Medical Services	165	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,405,699	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	5,052	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,052	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,972,201	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,697,165	31
32	Health Care	7,792,788	32
33	General Administration	3,488,873	33
	B. Capital Expense		
34	Ownership	2,559,174	34
	C. Ancillary Expense		
35	Special Cost Centers	1,150,023	35
36	Provider Participation Fee	188,276	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,876,299	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,904,098)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,904,098)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 133,232	44
45	Private Pay - Net Inpatient Revenue	677,870	45
46	Medicare - Net Inpatient Revenue	378,798	46
47	Other-(specify) HMO/Insurance	(604,930)	47
48	Other-(specify) VA/Hospice/Charity	(186,407)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 398,563	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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2,008	2,231	$ 107,323	$ 48.11	1
2	Assistant Director of Nursing	3,872	4,153	145,362	35.00	2
3	Registered Nurses	22,065	24,321	779,805	32.06	3
4	Licensed Practical Nurses	47,709	52,204	1,472,898	28.21	4
5	CNAs & Orderlies	70,810	82,808	1,103,026	13.32	5
6	CNA Trainees					6
7	Licensed Therapist	20,038	22,314	563,801	25.27	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,912	2,056	34,473	16.77	9
10	Activity Assistants	2,538	2,791	26,853	9.62	10
11	Social Service Workers	7,208	7,627	174,660	22.90	11
12	Dietician					12
13	Food Service Supervisor		31	787	25.39	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,429	5,827	82,212	14.11	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,864	2,009	122,568	61.01	20
21	Assistant Administrator					21
22	Other Administrative	13,408	14,508	344,055	23.71	22
23	Office Manager					23
24	Clerical	2,850	2,955	30,084	10.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,071	2,286	53,383	23.35	31
32	Other Health C: Medicare Coord					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,782	228,121	$ 5,041,290 *	$ 22.10	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		$ 527,561	1-3	35
36	Medical Director		78,000	9-3	36
37	Medical Records Consultant		4,400	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,172	10-3	39
40	Physical Therapy Consultant		969,572		40
41	Occupational Therapy Consultant		817,857		41
42	Respiratory Therapy Consultant			10a-3	42
43	Speech Therapy Consultant		229,733		43
44	Activity Consultant		2,688	11-3	44
45	Social Service Consultant			12-3	45
46	Other(specify) Admin		113,047	10-3	46
47	Xray & Laboratory		225,361	39-3	47
48	Dentis/Physician/Psychiatrist		128,500	39-3	48
49	TOTAL (lines 35 - 48)		$ 3,105,891		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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonzetta R Williams	Administrator		$ 86,908
Ayodeji T Adegoge	Administrator		33,160
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 120,068

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
Talx/Servarus/Bryan Cave LLP	New Hire/Survey/Legal	$ 135
Compsych Corp	Employee Services	1,208
Equifax, Inc	Background	655
Duane Morris LLP	Legal	55,070
Protitle USA/Probate Finder/Medica	Debt Collections/Tracing	1,079
Burgeon Legal Group	Legal	3,763
Perkins Eastman Architects	Architect/Desgin	1,612
Cass Information Systems Inc	Waste Expense Mgmt	1,488
LexisNexis	Data Research Mgmt	1,472
Mary Hupke BS MT	Survey Consultant	1,238
National Research	Survey Tracking	1,171
Various Misc Services	Nursing/Legal/Survey	648
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 69,539

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,959
Unemployment Compensation Insurance	85,975
FICA Taxes	374,816
Employee Health Insurance	183,225
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	4,501
Other Benefits	8,079
Home Office Payroll Taxes	78,179
TOTAL (agree to Schedule V, line 22, col.8)	$ 830,734

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	5,901
Health Care Worker Background Check	28,581
(Indicate # of checks performed)	
Patient Background Checks	
Publications and Manuals	2,614
Professional Dues	16,414
Other Licenses	8,170
Less: Public Relations Expense	( )
Non-allowable advertising	801
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,481

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,203
In-State Travel	7,481
Seminar Expense	8,091
Home Office Allocation	58,865
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 77,640

**See instructions.

Facility Name & ID Number Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Brentwood Sub Acute HC Ctr # 0052522 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. **IllinoisHealth Care Association $15,718**

(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. $ **27,554** 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. $ **188,276**
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. $ Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) 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.