

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

<p>I. IDPH License ID Number: <u>0047373</u></p> <p>Facility Name: <u>Westchester Health Rehab Ctr</u></p> <p>Address: <u>2901 South Wolf Road</u> <u>Westchester</u> <u>60154</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>708 531 1441</u> Fax # <u>708 409 1271</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/06/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Martha McDaniel</u> Telephone Number: <u>832 467 6317</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>SVP Operations Finance</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()</td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>SVP Operations Finance</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>SVP Operations Finance</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Westchester Health Rehab Ctr

0047373 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,618	743	4,399	27,760	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,618	743	4,399	27,760	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.21%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

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 Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 120 and days of care provided 1,907

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Westchester Health Rehab Ctr # 0047373 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		2,075	625,459	627,534		627,534	(171,834)	455,700		1
2	Food Purchase		1,867		1,867		1,867	171,811	173,678		2
3	Housekeeping		9,974	182,155	192,129		192,129		192,129		3
4	Laundry		8,888	119,291	128,179		128,179		128,179		4
5	Heat and Other Utilities			195,210	195,210		195,210	(6,639)	188,571		5
6	Maintenance	56,071	105,808	27,229	189,108		189,108	31,933	221,041		6
7	Other (specify):*			12,439	12,439		12,439		12,439		7
8	TOTAL General Services	56,071	128,612	1,161,783	1,346,466		1,346,466	25,271	1,371,737		8
	B. Health Care and Programs										
9	Medical Director			41,855	41,855		41,855		41,855		9
10	Nursing and Medical Records	2,623,256	196,627	134,556	2,954,439		2,954,439	305,762	3,260,201		10
10a	Therapy	528,179	64,908	1,144	594,231		594,231		594,231		10a
11	Activities	66,286	5,446	3,425	75,157		75,157		75,157		11
12	Social Services	69,873		660	70,533		70,533		70,533		12
13	CNA Training										13
14	Program Transportation			4,822	4,822		4,822		4,822		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,287,594	266,981	186,462	3,741,037		3,741,037	305,762	4,046,799		16
	C. General Administration										
17	Administrative	147,744			147,744		147,744	5,148	152,892		17
18	Directors Fees										18
19	Professional Services			41,445	41,445		41,445	(8,814)	32,631		19
20	Dues, Fees, Subscriptions & Promotions			35,319	35,319		35,319	(508)	34,811		20
21	Clerical & General Office Expenses	254,731	15,791	644,528	915,050		915,050	(539,123)	375,927		21
22	Employee Benefits & Payroll Taxes			656,315	656,315		656,315	43,830	700,145		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,721	15,721		15,721	(11,297)	4,424		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,152	38,152		38,152	955,939	994,091		26
27	Other (specify):*										27
28	TOTAL General Administration	402,475	15,791	1,431,480	1,849,746		1,849,746	445,175	2,294,921		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,746,140	411,384	2,779,725	6,937,249		6,937,249	776,208	7,713,457		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 Health Rehab Ctr

#0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			480,324	480,324		480,324	(19,499)	460,825			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			755,096	755,096		755,096	49,139	804,235			32
33	Real Estate Taxes			515,409	515,409		515,409	(145,799)	369,610			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							36,949	36,949			36
37	TOTAL Ownership			1,750,829	1,750,829		1,750,829	(79,210)	1,671,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,385	23,878	96,263		96,263		96,263			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,403	226,403		226,403		226,403			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		72,385	250,281	322,666		322,666		322,666			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,746,140	483,769	4,780,835	9,010,744		9,010,744	696,998	9,707,742			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 Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(6,704)	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	(23)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(34,283)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(152,426)	21		24
25	Fund Raising, Advertising and Promotional	(602)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (195,468)		\$	30

BHF USE ONLY							
48		49		50		51	

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	2	
		Amount	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)	541,096		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 541,096		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 345,628		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Westchester Health Rehab Ctr

ID# 0047373

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Back Office Services	\$ (389,874)	21	1
2	Prof Liability Insurance Adjustment	939,314	26	2
3	Depreciation Adj = Capital Lease Days	(19,499)	30	3
4	Reclass Raw Food Expense	(171,834)	1	4
5	Reclass Raw Food Expense	171,834	2	5
6	Real Estate Accrual Adj	(145,799)	33	6
7	Adjust Travel Expense	(32,170)	24	7
8	Non Allowable Advertsing	(602)	20	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	351,370		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(171,834)	0	0	0	0	0	0	0	0	0	0	(171,834)	1
2	Food Purchase	171,811	0	0	0	0	0	0	0	0	0	0	171,811	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	(6,704)	65	0	0	0	0	0	0	0	0	0	(6,639)	5
6	Maintenance	0	31,933	0	0	0	0	0	0	0	0	0	31,933	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,727)	31,998	0	0	0	0	0	0	0	0	0	25,271	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	305,762	0	0	0	0	0	0	0	0	0	305,762	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	305,762	0	0	0	0	0	0	0	0	0	305,762	16
	C. General Administration													
17	Administrative	0	5,148	0	0	0	0	0	0	0	0	0	5,148	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(34,283)	25,469	0	0	0	0	0	0	0	0	0	(8,814)	19
20	Fees, Subscriptions & Promotions	(1,204)	696	0	0	0	0	0	0	0	0	0	(508)	20
21	Clerical & General Office Expenses	(543,730)	4,607	0	0	0	0	0	0	0	0	0	(539,123)	21
22	Employee Benefits & Payroll Taxes	0	43,830	0	0	0	0	0	0	0	0	0	43,830	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(32,170)	20,873	0	0	0	0	0	0	0	0	0	(11,297)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	939,314	16,625	0	0	0	0	0	0	0	0	0	955,939	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	327,927	117,248	0	0	0	0	0	0	0	0	0	445,175	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	321,200	455,008	0	0	0	0	0	0	0	0	0	776,208	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westchester Health Rehab Ctr# 0047373

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(19,499)	0	0	0	0	0	0	0	0	0	0	(19,499) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	49,139	0	0	0	0	0	0	0	0	0	49,139 32
33	Real Estate Taxes	(145,799)	0	0	0	0	0	0	0	0	0	0	(145,799) 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	36,949	0	0	0	0	0	0	0	0	0	36,949 36
37	TOTAL Ownership	(165,298)	86,088	0	0	0	0	0	0	0	0	0	(79,210) 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)	155,902	541,096	0	0	0	0	0	0	0	0	0	696,998 45

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
Illinois Holdco LLC	100	Montebello Health Care Center	Hamilton	SSC 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 LLC		Consulting Services
		Westchester Healthcare Center0	Westchester			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 Utilities	\$	SSC Equity Holdings LLC	100.00%	\$ 65	\$	65 1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	31,933		31,933 2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	25,469		25,469 3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	696		696 4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	305,762		305,762 5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	4,607		4,607 6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	20,873		20,873 7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	16,625		16,625 8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	36,949		36,949 9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	5,148		5,148 10
11	V	35 Rental and Lease		SSC Equity Holdings LLC	100.00%			
12	V	32 Interest Income/Expense		SSC Equity Holdings LLC	100.00%	49,139		49,139 12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	43,830		43,830 13
14	Total		\$			\$ 541,096	\$ *	541,096 14

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

Facility Name & ID Number

Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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		Excell Health Care Center	Oakland				1
2			Flagship Heath care Center	Newport Beach				2
3			Tarzana Health & Rehab Center	Tarzana				3
4			Diamond Ridge Health Care Center	Pittsburgh				4
5			Courtyard Care Center	San Jose				5
6			Mission Carmichael Health Care Center	Carmichael				6
7			AlpineLiving Center	Thornton				7
8			Boulder Manor	Boulder				8
9			Pearl Street Health Care Center	Englewood				9
10			Applewood Living Center	Longmont				10
11			Fort Collins Health Care Center	Fort Collins				11
12			Spring Creek Healthcare Center	Fort Collins				12
13			Berthoud Living Center	Berthoud				13
14			Sierra Vista Health Care Center	Loveland				14
15			Windsor Health Care Center	Windsor				15
16			San Juan Living Center	Montrose				16
17			Four Corners Health Care Center	Durango				17
18			Palisade Living Center	Palisade				18
19			Colonial Columns Nursing Center	Colorado Springs				19
20			Cedarwood Health Care Center	Colorado Springs				20
21			Minnequa Medicenter	Pueblo				21
22			Terrace Gaedens Healthcare Center	Colorado Springs				22
23			Aspen Living Cente	Colorado Springs				23
24			Centennial Heathcare Center	Greeley				24
25			Kenton Manor	Greeley				25
26			Stering Living Center	Sterling				26
27			Sunset Manor	Brush				27
28			Yuma Life Care Center	Yuma				28
29			Jewell Care Center of Denver	Denver				29
30			Monaco Parkway	Denver				30

Facility Name & ID Number

Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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		Garden Square at Spring Creek	Fort Collins				1
2			Pendleton Health & Rehab	Mystic				2
3			Bride Brook Health & Rehab	Niantic				3
4			Brian Center Nursing Care Austell	Austill				4
5			Brian Center Health & Rehab Canton	Canton				5
6			Northeast Atlanta Healty & Rehab	Atlanta				6
7			Brighton Place West	Topeka				7
8			Indian Creek Healht Care Center	Overland Park				8
9			SE Massachusetts Health & Rehab	New Bedford				9
10			Methuen Health & Rehab Center	Methuen				10
11			Patuxent River Health & Rehab Center	Laurel				11
12			Arcola Heathh & Rehab Center	Silver Spring				12
13			Glen Burnie Health & Rehab Center	Glen Burnie				13
14			Overlea Health & Rehab Center	Baltimore				14
15			Bethesda Health & Rehab Center	Bethesda				15
16			Summit Park Health & Rehab Center	Catonsville				16
17			North Arundel Health & Rehab Center	Glen Burnie				17
18			Bel Air Health & Rehab Center	Bel Air				18
19			Forest Hill Health & Rehab Center	Forest Hill				19
20			Heritage Harbour Health & Rehab Center	Annapolis				20
21			Cambridge East	Madison Heights				21
22			Cambridge North	Clawson				22
23			Cambridge South	Beverly Hills				23
24			Clarkston	Clarkston				24
25			Clinton-Aire Healthcare Center	Clinton Township				25
26			Crestmont NursingCare Center	Fenton				26
27			Heritage Manor	Flint				27
28			Hope Health Care Center	Westland				28
29			Warren Woods Health Care Center	Warren				29
30			Superior Woods Health Care Center	Ypsilanti				30

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	Countrybrook Living Center	Brook Haven				1
2			Brian Center Health & Rehab Eden	Eden				2
3			Brian Center Nursing Care Lexington	Lexington				3
4			Brian Center Health & Rehab Hickory East	Hickory				4
5			Brian Center Health & Rehab Wilson	Wilson				5
6			Randolph Health & Rehab Center	Asheboro				6
7			Brian Center Health & Rehab Winston Salem	Winston Salem				7
8			Brian Center Health & Rehab Charlotte	Charlotte				8
9			Brian Center Health & Rehab Windsor	Windsor				9
10			Maple Leaf Health Care	Statesville				10
11			Brian Center Health & Rehab Weaverville	Weaverville				11
12			Brian Center Health & Rehab Lincolnton	Lincolnton				12
13			Brian Center Health & Rehab Wallace	Wallace				13
14			Brian Center Health & Rehab Monroe	Monroe				14
15			Brian Center Health & Rehab Durham	Durham				15
16			Brian Center Health & Rehab Goldsboro	Goldsboro				16
17			Brian Center Health & Rehab Cabarrus	Concord				17
18			Brian Center Nursing Care Shamrock	Charlotte				18
19			Brian Center Nursing Care Hickory	Hickory				19
20			Brian Center Health & Rehab Center Waynesvi	Waynesville				20
21			Brian Center Health & Rehab Clayton	Clayton				21
22			Brian Center Health & Rehab Brevard	Bervard				22
23			Brian Center Health & Rehab Yanceyville	Yanceyville				23
24			Brian Center Health & Rehab Hertfort	Hertford				24
25			Brian Center Health & Rehab Spruce Pine	Spruce Pine				25
26			Brian Center Health & Rehab Hendersonville	Hendersonville				26
27			Brian Center Health & Rehab Salisbury	Salisbury				27
28			Mariner Health Care of Wilmington	Wilmington				28
29			Silver Stream Health & Rehab	Wilmington				29
30			Kenansville Health & Rehab	Kenansville				30

Facility Name & ID Number

Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	Charlotte Apts	Charlotte				1
2			Forest City Health & Rehab	Forest City				2
3			North Hills Health & Rehab	Wexford				3
4			West Hills Health & Rehab	Coraopolis				4
5			Broomall Health & Rehab	Broomall				5
6			Seneca Health & Rehab	Seneca				6
7			Sumter East Health & Rehab	Sumter				7
8			Golden Age Inman	Inman				8
9			Inman Healthcare	Inman				9
10			Lebanon Health & REhab	Lebanon				10
11			Greenhills Health & Rehab	Nashville				11
12			Norris Health & Rehab	Andersonville				12
13			Newport Health & Rehab	Newport				13
14			Cheyenne Healthcare	Cheyenne				14
15			Poplar Living Center	Casper				15
16			Sheridan Manor	Sheridan				16
17			Huntington Health Care	Huntington				17
18			Bastrop Nursing Center	Bastrop				18
19			Care Inn of La Grange	La Grange				19
20			Kountze Nursing Center	Kountze				20
21			Retama Manor Nursing Center San Antonio No	San Antonio				21
22			Retama Manor Nursing Center San Antonio We	San Antonio				22
23			Retama Manor Nursing Center Alice	Alice				23
24			Retama Manor Nursing Center Edinburg	Edinburg				24
25			Retama Manor Nursing Center Harlingen	Harlingen				25
26			Retama Manor Nursing Center Jourdanton	Jourdanton				26
27			Retama Manor Nursing Center Laredo South	Laredo				27
28			Retama Manor Nursing Center Laredo West	Laredo				28
29			Retama Manor Nursing Center McAllen	McAllen				29
30			Retama Manor Nursing Center Pleasanton Nort	Pleasanton				30

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	Retama Manor Nursing Center Pleasanton Sout	Pleasanton				1
2			Retama Manor Nursing Center Rio Grande City	Rio Grande City				2
3			Retama Manor Nursing Center Robstown	Robstown				3
4			Retama Manor Nursing Center Weslaco	Weslaco				4
5			Weatherford health Care Center	Weatherford				5
6			Peach Tree Place	Weatherford				6
7			Retama Manor Nursing Center Raymondville	Raymondville				7
8			Memorial City Health and Rehab	Houston				8
9			Jacinto City Healthcare Center	Houston				9
10			Spring Branch Healthcare Center	Houston				10
11			Retama Manor Nursing Center Corpus Christi	Corpus Christi				11
12			Downtown Health & Rehab	Fort Worth				12
13			Lakeshore Village Healthcare Center	Waco				13
14			Deer Creek of Wimberley	Wimberley				14
15			La Paloma Nursing Center	San Diego				15
16			Pine Arbor	Silsbee				16
17			Las Palmas Healthcare Center	McAllen				17
18			Hilltop Village	Kerville				18
19			Silver Creek Manor	San Antonio				19
20			Alpine Terrace	Kerrville				20
21			Edgewater Care Center	Kerrville				21
22			Arlington Heights Health & Rehab	Fort Worth				22
23			The Meadows Health & Rehab	Dallas				23
24			Northgate Health & Rehab	San Antonio				24
25			Interlochen Health & Rehab	Arlington				25
26			First Colony Health & Rehab	Missouri City				26
27			Cypresswood Health & Rehab	Houston				27
28			Northwest Health & Rehab	Houston				28
29			The Westbury Place	Houston				29
30			Westchase Health & Rehab	Houston				30

Facility Name & ID Number

Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	Woodwind Lakes Health & Rehab	Houston				1
2			Pasadena Care Center	Pasadena				2
3			Bay Villa	Bay City				3
4			Alice Health care Center	Alice				4
5			Bangs Nursing Home	Bangs				5
6			Brazosview	Richmond				6
7			Courtyards at Fort Worth	Fort Worth				7
8			Faith Memorial	Pasadena				8
9			Golden Years	Marlin				9
10			Greenview Manor	Waco				10
11			Hillview Health & Rehab	Goldthwaite				11
12			Levelland Health Care	Levelland				12
13			Longmeadow Health Care	Justin				13
14			Memorial Medical Nursing Center	San Antonio				14
15			Mount Pleasant	Mount Pleasant				15
16			North Park Health & Rehab	McKinney				16
17			Pampa Health Care Center	Pampa				17
18			Park Highlands Health Care Center	Athens				18
19			Pleasant Springs Health Care Center	Mount Pleasant				19
20			Sweeny Health Care Center	Sweeny				20
21			Texoma Health Care Center	Sherman				21
22			The Park in Plano	Plano				22
23			Ashland Health & Rehab	Ashland				23
24			Southpointe Health Care Center	Greenfield				24
25			Virginia Highlands Health & Rehab Center	Germantown				25
26			Grande Prairie Health & Rehab Center	Pleasant Prairie				26
27			Pleasant Valley Health Care Center	Derry				27
28			The Village at Alameda	Albuquerque				28
29			Hobbs Healthcare Center	Hobbs				29
30			Lake Mead Health Care Center	Henderson				30

Facility Name & ID Number Westchester Health Rehab Ctr # 0047373 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending: 2/31/2020

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 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
 Phone Number (832 467 6000
 Fax Number (832 467 6384

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities			\$	\$		65	1
2	6	Repair and Maintenance						31,933	2
3	19	Professional Services						25,469	3
4	20	Fee, Subscriptions and Promos						696	4
5	10	Nursing & Medical Records						305,762	5
6	21	Clerical & Gen Office Exp						4,607	6
7	24	Travel & Seminar						20,873	7
8	26	Insurance						16,625	8
9	36	Drpreiation						36,949	9
10	17	Communications						5,148	10
11	35	Rental and Lease							11
12	32	Interest Income/Expense						49,139	12
13	22	Payroll Taxes						43,830	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				\$	\$		541,096	25

Facility Name & ID Number

Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.		\$	312,658	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.)		\$	369,310	2
3. Under or (over) accrual (line 2 minus line 1).		\$	56,652	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	515,109	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.		\$	571,761	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	343,195	8
	2016	355,878	9
	2017		10
	2018	357,486	11
	2019	364,478	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westchester Health Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047373

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>15-29-300-018-0000</u>	<u>2901 S Wolfe Rd</u>	\$ <u>369,310.00</u>	\$ <u>369,310.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>369,310.00</u></u>	\$ <u><u>369,310.00</u></u>

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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. (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1, 2, 3). Row 3 is shaded and labeled 'TOTALS'.

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

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XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		10			6,484	9
10	Concrete Sidewalk 1/3 downpayment	2005		1,628		12			1,628	10
11	12.5 Ton RTU - Kitchen - Balance	2005		6,484		10			6,484	11
12	Concrete Sidewalk	2005		3,389	1,390	11.5	1,390		3,389	12
13	Plumbing Project	2005		4,750		11.8			4,750	13
14	Plumbing Repairs	2005		10,000		11.8			10,000	14
15	Instl Door w/Closer - Exit Device	2005		2,576		11.5			2,576	15
16	Mixing Valve Spout - Kitchen	2005		2,207		11.5			2,206	16
17	Dry Sprinkler System Repair	2005		2,159		11.5			2,159	17
18	Repair Dry Sprinkler System	2005		1,893		11.5			1,893	18
19	Heat Pump	2005		1,255		11.5			1,255	19
20	Double Swing Gates - Dumpster	2005		1,226		8			1,226	20
21	Heat - Shower Room	2005		19,832		10			19,832	21
22	Remove Carpet and Install Tile	2005		37,384		10			37,384	22
23										23
24	Emergency Generator	2006		2,907	1,227	11.25	1,227		2,907	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		10			7,122	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		10.5			7,050	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 Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		10			1,778	41
42	Cove Base/Refurb	2006	2,462		5			2,462	42
43	Use Tax - Cove Base/Refurb	2006	171		5			171	43
44	Painting Resident Rooms - Balance	2006	6,700		5			6,700	44
45	Paint for Refurb	2006	637		5			637	45
46	Paint for Refurb	2006	499		5			499	46
47	Paint for Refurb	2006	360		5			360	47
48	Crash Rails	2006	550		10.25			550	48
49	Crash Rails for Walls	2006	2,961		10.42			2,961	49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269		10			269	51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21		10			21	52
53	Carpet/Labor	2007	4,440		5			4,440	53
54	Front Automatic Doors - Balance	2007	7,122		10			7,122	54
55	10: Overbed Lights	2007	1,689		10			1,689	55
56	Use Tax - 10: Overbed Lights	2007	131		10			131	56
57	59: Wall Boxes/Sconce Lights	2007	1,675		10			1,675	57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127		10			127	58
59	Remodel North & South Front Exit	2007	1,049		9.75			1,049	59
60	Heat/Cool Unit	2007	959		9.83			959	60
61	Connect Kit Heat/AC Unit	2007	46		9.83			46	61
62	Repair to Walk In Freezer	2007	5,177		9.92			5,177	62
63	Fire Sprinkler Repair	2007	2,826		9.92			2,826	63
64	Design Fee	2007	2,900		10.08			2,900	64
65	Design Fee	2007	225		10.08			225	65
66	50 Overbed Lights and Wall Sconces	2007	8,572		10.16			8,572	66
67	50 Overbed Lights and Wall Sconces	2007	664		10.16			664	67
68	61 Mount Wall Box Sconces	2007	1,741		9.92			1,741	68
69	61 Mount Wall Box Sconces	2007	135		9.92			135	69
70	TOTAL (lines 4 thru 69)		\$ 210,809	\$ 2,617		\$ 2,617	\$	\$ 210,807	70

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 210,809	\$ 2,617		\$ 2,617	\$	\$ 210,807	1
2	29 Oxygen Concentrators	2007	15,536		9.75			15,536	2
3	29 Oxygen Concentrators	2007	1,204		9.75			1,204	3
4	Cr: Void Ck Village Westchester	2007	(1,049)		9.75			(1,049)	4
5	Permit Fee to Remode;	2007	1,049		9.66			1,049	5
6	Connection Kit Heat/Cool Unit	2007	46		9.83			46	6
7	2 Connect Kits Heat/AC Units	2007	92		9.83			92	7
8	Cr on Heat/AC Unit	2007	(891)		9.75			(891)	8
9	4 Heat/Cool Units	2007	3,564		9.83			3,564	9
10	4 Power Conn Kits Heat/AC Units	2007	201		9.83			201	10
11	Furnace Repair	2007	1,380		9.83			1,380	11
12	Heat Repair	2007	3,033		10			3,033	12
13	Repair 8 Heat AC Units	2007	11,700		10			11,700	13
14	Boiler Repair	2007	661		9.75			661	14
15	Remodel North/Southwest Exits	2007	53,930		9.58			53,930	15
16	AC Unit	2007	4,835		10			4,835	16
17	AC Unit	2007	375		10			375	17
18	Water Heater	2007	1,866		9.75			1,866	18
19	Stainless Steel End Wall Kitchen	2007	1,261		9.41			1,261	19
20									20
21	2:AC Compressor Units	2008	9,874		9.25			9,874	21
22	Steel Door	2008	1,675		9			1,675	22
23	Furnace 50% Deposit	2008	2,759		8.75			2,759	23
24	Compressor For Cooling System	2008	3,993		9.33			3,993	24
25	Furnace -Final Payment	2008	2,759		8.66			2,759	25
26	Steel Door - Balance	2008	1,675		8.75			1,675	26
27	2: Zoneline Heat/Cool Units	2008	1,341		8.66			1,341	27
28	Heat Exchanger for Boiler	2008	7,510		8.58			7,510	28
29	6: Zoneline heat/Cool Units	2008	3,636		5			3,636	29
30	AT&T Circuit Conversion	2008	32,788		8.16			32,788	30
31	AT&T Circuit Conversion	2008	6,306		8			6,306	31
32	Blower Assembly	2008	3,511		8			3,511	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 387,429	\$ 2,617		\$ 2,617	\$	\$ 387,427	34

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 387,429	\$ 2,617		\$ 2,617	\$	\$ 387,427	1
2	3: Zoneline Heat/Cool Units	2009	1,999		7.42			1,999	2
3	Condenser fan motor	2009	8,348		7.5			8,348	3
4	2: Zoneline Heat/Cool Units	2009	1,333		7.34			1,333	4
5	Front Entry Paint	2009	6,241		5			6,241	5
6	Replace Gaas Valve & Thermometer	2009	2,500		7			2,500	6
7									7
8	2: Zoneline Heat/Cool Units	2010	1,346		7			1,346	8
9	Wanderguard	2010	2,744		7			2,744	9
10	Attic Sprikler System	2010	33,760		6.66			33,760	10
11	Replaced Heat Exchanger	2010	8,224		6.92			8,224	11
12	Rplc Furnace Thermostate & Sensor	2010	2,512		6.92			2,512	12
13	Zoneline Heat/Cool Unit	2010	568		5			568	13
14	3: Zoneline Heat/Cool Units	2010	1,968		6.75			1,968	14
15	Attic Sprikler System	2010	52,686		0.92			52,686	15
16	Attic Sprikler System	2010	47,056		6.92			47,056	16
17	Rplc Bearing Assembly & Blower Motor	2010	6,357		6.83			6,357	17
18	Attic Sprikler System	2010	8,025		6.92			8,025	18
19	Site Survey	2010	225		6.16			225	19
20	Compressor Unit	2010	3,102		6.16			3,102	20
21	Rplc Water Heater	2010	10,077		6.25			10,077	21
22	Replace Tempering Valves	2010	4,740		6.08			4,740	22
23									23
24	Maglock	2011	798		6.34			798	24
25	3: Zoneline Heat/Cool Units	2011	2,202		6			2,202	25
26	Facility Building Sign	2011	2,203		6.5			2,203	26
27									27
28	Dry Pendant Sprinkler Heads	2012	5,598		5			5,598	28
29	3: Zoneline Heat/Cool Units	2012	2,343		5			2,343	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 604,384	\$ 2,617		\$ 2,617	\$	\$ 604,382	34

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 604,384	\$ 2,617		\$ 2,617	\$	\$ 604,382	1
2	Mixing Valves	2013	5,790		44			5,790	2
3	Heat Draft Inducer Motor	2013	4,043		4			4,043	3
4	Aluminum Light Pole	2013	3,200		4			3,200	4
5	Inducer	2013	3,571		3.75			3,571	5
6	5: Duct Detectors	2013	3,035		3.75			3,035	6
7	Inducer - Credit Memo	2013	(689)		3.83			(689)	7
8	A/C Motor Kitchen Area	2013	1,642		3.75			1,642	8
9	Relays for Duct Smoke Detector	2013	1,000		3.67			1,000	9
10	19: Damper Actuators	2013	4,370		3.58			4,370	10
11	12: Damper Actuators	2013	1,338		3.58			1,338	11
12	Generator Transfer Switch	2013	4,722		3.58			4,722	12
13	12 Damper Actuators	2013	1,338		3.58			1,338	13
14	A/C Compressor Unit #1	2013	3,668		3.5			3,668	14
15	A/C Compressor & Condenser Fan	2013	3,580		3.42			3,580	15
16	Hot Water Booster Heater - Dishwasher	2013	2,529		3.42			2,529	16
17	7: Exhaust Vents	2013	1,332		3.25			1,332	17
18	Motor for Unit #8	2013	2,268		3.25			2,268	18
19	Bearing Assembly Water Heater	2013	2,960		3.25			2,960	19
20	Gas Valve and Ignition Control	2013	2,294		3.17			2,294	20
21									21
22	PTAC Unit	2014	847		3			847	22
23	PTAC Unit	2014	847		3			847	23
24	A/C Heating Units 9A & 9B	2014	14,770		3			14,770	24
25	3: Exhaust Fan Motors	2014	3,235	332	9.3	332		2,240	25
26	Condensing Unit for # 3 A/C	2014	3,157	265	12	265		1,722	26
27	A/C Condenser Fan Motors	2014	1,766	148	12	148		963	27
28	Mixing Valve Cartridge	2014	2,535	254	10	254		1,648	28
29	Split A/C System- Laundry & Hall	2014	14,370	1,437	10	1,437		9,221	29
30	Condenser for Walkin Freezer	2014	7,790	658	11.83	658		4,224	30
31	Door Closer & Hing System	2014	3,074	262	11.75	262		1,657	31
32	10: LCN 4040 24v Door Holder	2014	7,329	733	10	733		4,764	32
33	11: Aluminum 24 LCN Closer Door	2014	7,376	637	11.5	637		3,927	33
34	TOTAL (lines 1 thru 33)		\$ 723,471	\$ 7,343		\$ 7,343	\$	\$ 703,203	34

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 723,471	\$ 7,343		\$ 7,343	\$	\$ 703,203	1
2	Fan Guard on Walk In Cooler	2015	1,956	196	10	196		1,108	2
3	Installed LP Switch on A/C Units	2015	2,227	223	10	223		1,262	3
4	Replaced Water Level Probe n Ice Machine	2015	2,447	245	10	245		1,387	4
5	Unit Pump on Boiler/Furnace #1	2015	3,185	318	10	318		1,858	5
6	Unit Pump on Boiler/Furnace #2	2015	2,650	265	10	265		1,546	6
7	R22 Condensor Replacement on A/C	2015	2,325	211	11	211		1,180	7
8	Water Heater Part - Heat	2015	643	64	10	64		434	8
9	Compressor for A/C Unit	2015	2,325	211	11	211		1,180	9
10	Install 15 door closers and magnets	2015	4,906	490	10	490		3,149	10
11	CMBS Asphalt Pavement	2015	25,125	3,141	8	3,141		19,629	11
12	Install Parking Lot Tactile & Sign	2015	2,000	171	11.67	171		1,072	12
13	Wood Window and Doors	2015	5,958	511	11.67	511		3,191	13
14	Shower Room Renovation - ADA Bariatric Shower Rebuilds	2015	55,600	5,026	11.33	5,026		28,376	14
15	Install New Control Board Blower on Furnace	2015	2,947	258	11.41	258		1,549	15
16	Install Gas Valve on Furnace	2015	1,488	149	10	149		893	16
17	Replaced Air Curtain on Freezer	2015	895	79	11.33	79		467	17
18	Walk in Freezer Aluminum Plate	2015	1,795	161	11.16	161		924	18
19	Norstar Phone System Install	2015	6,179	618	10	618		3,192	19
20	PTAC Resistance Heater	2015	767	141	5	141		767	20
21									21
22	Replaced Bearing and Shaft	2016	3,165	275	11.5	275		1,674	22
23	Circulating Pump	2016	2,707	271	10	271		1,466	23
24	Motor for Walk in Freezer	2016	5,367	495	10.8	495		2,684	24
25	Valves, Coupling and Thermometer	2016	6,185	618	10	618		3,350	25
26	Door Closer	2016	1,777	176	10	176		822	26
27	Data Board for Water Heater	2016	1,488	149	10	149		756	27
28	Kitchen Hot Water Compliance	2016	6,443	629	10.1	629		3,038	28
29	PTAC Resistance Heater	2016	1,468	294	5	294		1,419	29
30	Remove and Replace all plumbing, electrical and shower walls	2016	12,931	1,176	11	1,176		6,563	30
31	PTAC Resistance Heater	2016	734	147	5	147		697	31
32	Mixing Valve Cartridges	2016	3,276	328	10	328		1,529	32
33	PTAC Resistance Heater	2016	734	147	5	147		661	33
34	TOTAL (lines 1 thru 33)		\$ 895,164	\$ 24,526		\$ 24,526	\$	\$ 801,026	34

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 895,164	\$ 24,526		\$ 24,526	\$	\$ 801,026	1
2	Upgrading Landscape	2016	12,000	1,210	11	1,210		5,445	2
3	Installed New Mini Split AC	2016	10,294	1,047	5	1,047		4,625	3
4	Installed Backflow Fire Device	2016	12,167	1,237	10	1,237		5,465	4
5	Replaced Radiator Generator	2016	4,542	466	5	466		2,019	5
6	Garbage Disposal 2 hp	2016	1,651	330	10	330		1,376	6
7	5 PTACs	2016	3,671	734	9.83	734		2,997	7
8									8
9	Control Board - Furnace	2017	1,133	76	15	76		283	9
10	3: Exhaust Fan Motors - Kitchen	2017	3,391	339	10	339		1,187	10
11	Condensor Motor for AC Unit #15	2017	2,260	151	15	151		515	11
12									12
13									13
14	3: GE Zoneline PTAC	2018	2,630	526	5	526		1,315	14
15	Handicap Door Operator System	2018	3,394	226	15	226		566	15
16	Kitchen Hood Exhaust Fan Motor	2018	4,879	488	10	488		1,220	16
17	A/C Compressor/Evaporator Coil	2018	8,009	534	15	534		1,246	17
18									18
19	4: GE Zoneline PTAC 265 V	2019	4,615	923	5	923		1,769	19
20	Blower Motor Lennox Furnace	2019	1,751	99	17.67	99		190	20
21	10: Exterior Light Fixtures	2019	6,170	617	10	617		1,182	21
22	100 gal Water Heater - Laundry	2019	10,200	1,020	10	1,020		1,700	22
23	Water Softner - Dish Machine	2019	1,751	175	10	175		277	23
24	H/M door - Laundry room	2019	2,725	159	17	159		213	24
25	6: Lennox A/H Furnace	2019	10,170	598	17	598		748	25
26	Hot Water Heat Exchanger	2019	4,005	400	10	400		501	26
27	Watts Mixing Valve	2019	3,675	367	10	367		459	27
28	Commercial Disposal 1 HP - Prep Sink	2019	1,159	232	5	232		290	28
29	8: Motor Fire Damper	2019	7,290	729	10	729		961	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,018,696	\$ 37,209		\$ 37,209	\$	\$ 837,575	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,018,696	\$ 37,209		\$ 37,209	\$	\$ 837,575	1
2	2020	4,895	530	10	530		530	2
3	2020	12,430	800	17	800		800	3
4	2020	4,615	923	5	923		923	4
5	2020	7,250	725	10	725		725	5
6	2020	12,945	809	8	809		809	6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 1,060,831	\$ 40,996		\$ 40,996	\$	\$ 841,362	34

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	\$ 544,173	\$ 13,311	\$ 13,311	\$		\$ 13,311	71
72	Current Year Purchases	30,970	1,971	1,971			1,971	72
73	Fully Depreciated Assets	(18,034)						73
74								74
75	TOTALS	\$ 557,109	\$ 15,282	\$ 15,282	\$		\$ 15,282	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)	\$ 1,617,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,278	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,278	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)	\$ 856,644	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 Health Rehab Ctr

0047373

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SSC Equity Holdings LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. 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:	<u>1988</u>	<u>120</u>	<u>10/11/2013</u>	\$	<u>12</u>		<u>3</u>
4	Additions							<u>4</u>
5								<u>5</u>
6								<u>6</u>
7	TOTAL		<u>120</u>		\$			<u>7</u>

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.	<u>/2021</u>	\$	
13.	<u>/2022</u>	\$	
14.	<u>/2023</u>	\$	

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 NO Terms: _____*

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			\$	\$	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	TOTAL		\$	\$	<u>21</u>

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	3709 hrs	\$ 155,457		\$	\$	3,709	\$ 155,457	1
2	Licensed Speech and Language Development Therapist	10a-03	1867 hrs	91,480				1,867	91,480	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	6334 hrs	272,416				6,334	272,416	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				72,385		72,385	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			\$ 519,353		\$	\$ 72,385	11,910	\$ 591,738	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 800	\$	1
2	Cash-Patient Deposits	716		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	238,254		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,098		6
7	Other Prepaid Expenses	2,080		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 243,948	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	68,576		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	8,637,027		15
16	Equipment, at Historical Cost	557,109		16
17	Accumulated Depreciation (book methods)	(3,065,368)		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):	2,506		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,199,850	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,443,798	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 650,228	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	898,904		30
31	Accrued Taxes Payable (excluding real estate taxes)	125,857		31
32	Accrued Real Estate Taxes(Sch.IX-B)	510,277		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	77,737		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,263,003	\$	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	<u>CLO & Intercompany</u>	13,995,579		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 13,995,579	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,258,582	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,814,784)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,443,798	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,602,725)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,602,725)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,212,059)	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)	\$ (1,212,059)	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)	\$ (9,814,784)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 23,161,046	1
2	Discounts and Allowances for all Levels	(16,763,167)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,397,879	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,295,600	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,295,600	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	93,479	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,520	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 103,999	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	<u>General Rental Receipts</u>	1,207	28
28a	<u>Misc Receipts Vending</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,207	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,798,685	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,346,466	31
32	Health Care	3,741,037	32
33	General Administration	1,849,746	33
B. Capital Expense			
34	Ownership	1,750,829	34
C. Ancillary Expense			
35	Special Cost Centers	96,263	35
36	Provider Participation Fee	226,403	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,010,744	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,212,059)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,212,059)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,132,524	44
45	Private Pay - Net Inpatient Revenue	243,779	45
46	Medicare - Net Inpatient Revenue	813,634	46
47	Other-(specify) <u>HMO/Ins</u>	(935)	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	1,208,877	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,397,879	49

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

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

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

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

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,911	2,084	\$ 116,745	\$ 56.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,565	18,650	805,529	43.19	3
4	Licensed Practical Nurses	22,539	23,987	819,247	34.15	4
5	CNAs & Orderlies	41,989	44,540	881,735	19.80	5
6	CNA Trainees					6
7	Licensed Therapist	10,820	12,043	528,179	43.86	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,779	2,012	46,783	23.25	9
10	Activity Assistants	1,341	1,405	19,503	13.88	10
11	Social Service Workers	2,684	2,881	69,873	24.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,007	2,082	56,071	26.93	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,024	2,157	137,569	63.78	20
21	Assistant Administrator					21
22	Other Administrative	7,043	7,670	207,395	27.04	22
23	Office Manager					23
24	Clerical	87	253	57,511	227.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,789	119,764	\$ 3,746,140 *	\$ 31.28	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 624,167	1-3	35
36	Medical Director	41,855	9-	36
37	Medical Records Consultant	2,800	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	10,180	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	1,144	10a-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,495	11-3	44
45	Social Service Consultant	660	12-3	45
46	Other(specify)	45,523	10-3	46
47	Administrative	22,993	39-3	47
48	Laboratory & Xray			48
49	TOTAL (lines 35 - 48)	\$ 751,817		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Libby A Rusink	Administrator	0	\$ 71,520	Workers' Compensation Insurance	\$ 85,741	IDPH License Fee	\$		
John Calvo Sianghio	Administrator	0	65,952	Unemployment Compensation Insurance	30,567	Advertising: Employee Recruitment	9,383		
Hina J Rehman	Administrator	0	10,272	FICA Taxes	275,405	Health Care Worker Background Check	4,640		
				Employee Health Insurance	228,564	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	2,090		
				Employee Life Ins	1,751	Dues	13,384		
				Other Benefits	34,287	Other Licenses	5,220		
				Home Office Payroll Taxes	43,830	Fees, Subscriptions and Promos	696		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 147,744	TOTAL (agree to Schedule V, line 22, col.8)		\$ 700,145			
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising (602)		
			\$				Yellow page advertising ()		
							TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 34,811		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
C. Professional Services							Description		
Vendor/Payee	Type		Amount	Description	Line #	Amount		Amount	
Avalere Health	Vantage CPS		\$ 1,152			\$	Out-of-State Travel	\$	
Docusign Inc	New Hire Paperwok		73						
Equifax	Background Checks		710						
LexisNexis	Regs Resource		110				In-State Travel		
Mgmt Network Srvc	Network Membership		375						
NRC Health	Survey Program		177						
Pinnacle Quality Insight	Cust Satisfaction Survey		1,056				Seminar Expense	4,424	
Probate Finder	Probate Search		140						
Regional Real Estate Valuation	Appraisal Service		3,000						
Worsek & Vihon	RE Object court filing fee		368						
Stottler Hayes Group	Legal Fees		34,283				Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 41,444	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,424

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Westchester Health Rehab Ctr

0047373

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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 \$12,427
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,335 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? _____
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. \$ 226,403
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. \$ Yes
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman LLC (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. NA
Attach invoices and a summary of services for all architect and appraisal fees.