



Facility Name & ID Number Westchester Health & Rehab Ctr# 0047373 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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 120

	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	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

## B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
		8	SNF	22,563	5,209	
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,563	5,209	8,084	35,856	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 81.86%

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

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. Does the facility maintain a daily midnight census? YesG. 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 10/01/1989

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 10/01/1989 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 7,276Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Westchester Health & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
<b>A. General Services</b>											
1	Dietary	243,163	19,045	19,604	281,812		281,812		281,812		1
2	Food Purchase		164,576		164,576		164,576		164,576		2
3	Housekeeping	152,581	14,377		166,958		166,958		166,958		3
4	Laundry	54,923	9,907		64,830		64,830		64,830		4
5	Heat and Other Utilities			175,049	175,049		175,049	74	175,123		5
6	Maintenance	50,735	63,134	18,396	132,265		132,265	17,235	149,500		6
7	Other (specify):*			26,184	26,184		26,184		26,184		7
8	<b>TOTAL General Services</b>	<b>501,402</b>	<b>271,039</b>	<b>239,233</b>	<b>1,011,674</b>		<b>1,011,674</b>	<b>17,309</b>	<b>1,028,983</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	2,240,980	150,989	160,915	2,552,884		2,552,884		2,552,884		10
10a	Therapy	530,986	128,609	18,358	677,953		677,953		677,953		10a
11	Activities	81,562	3,835	4,949	90,346	965	91,311		91,311		11
12	Social Services	64,615		2,976	67,591		67,591		67,591		12
13	CNA Training										13
14	Program Transportation		25	2,994	3,019	(3,216)	(197)		(197)		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,918,143</b>	<b>283,458</b>	<b>206,992</b>	<b>3,408,593</b>	<b>(2,251)</b>	<b>3,406,342</b>		<b>3,406,342</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	98,462			98,462		98,462		98,462		17
18	Directors Fees			724	724		724		724		18
19	Professional Services			49,311	49,311		49,311	(47,075)	2,236		19
20	Dues, Fees, Subscriptions & Promotions			92,835	92,835		92,835	1,017	93,852		20
21	Clerical & General Office Expenses	327,057	25,513	541,405	893,975		893,975	(382,397)	511,578		21
22	Employee Benefits & Payroll Taxes			659,607	659,607		659,607	15,081	674,688		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,255	8,255		8,255	24,298	32,553		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			113,095	113,095		113,095	(56,281)	56,814		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>425,519</b>	<b>25,513</b>	<b>1,465,232</b>	<b>1,916,264</b>		<b>1,916,264</b>	<b>(445,357)</b>	<b>1,470,907</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,845,064</b>	<b>580,010</b>	<b>1,911,457</b>	<b>6,336,531</b>	<b>(2,251)</b>	<b>6,334,280</b>	<b>(428,048)</b>	<b>5,906,232</b>		<b>29</b>

\*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.

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2007

Page -3.1

Facility Name & ID Number Westchester Health and Rehab

#

0042374

Ending: 12/31/2007

**SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES**

**Operating Expense - pg 3 Line 7**

**Amount**

Infectious Waste Disposal <> Default <> Nursing Admin/Supv	800019000008000	8,847
Infectious Waste Disposal <> Default <> Physical Plant	800019000008210	
Garbage Service<>Default<>Prod<>Physical Plant	810002000008210	17,337
<u>Garbage Service &lt;&gt; Default &lt;&gt; Physical Plant</u>	<u>810072000008210</u>	
		<u>26,184</u>

**Health Care Program - pg 3 Line 15**

**Amount**

<u>Salaries - Regular &lt;&gt; Non Supervisor &lt;&gt; HHA (General)</u>	<u>700000700203500</u>	
		<u>0</u>

**General & Administrative - Line 27**

**Amount**

N/A		
		<u>0</u>

**Inservice Education - Line 23 Column 3 (over \$2,000)**

**Amount**

N/A		
		<u>0</u>

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2007

Page -3.2

Facility Name & ID Number Westchester Health and Rehab # 0042374

Ending: 12/31/2007

Meals - adjustment

Sales Tax - adjustment

43,800 Days ( Total Patient days)  
 3 Mult (3 meals a day)  
 131,400 Sub total  
 13 meals to employess (reported by facility)  
 131,413 Add Sub  
 164,576 Divide -Pg 3, line 2, column 2  
 1.25 Cost per day

164,576 Total Food Cost (page 3,Line 2, col 2)  
 0.01 Mult  
 1645.76 Sub total  
 7.26% Mult (Pvt pay div by total census)  
 120 = adjust for nonallowable sale tax  
 for page 5A,

1.25 Cost per day  
 13 mult - meal to employees  
 16 = adjust for pg 2, line 2, column2

Reclassification V

Page 3 Line 6 col 02

Repair & Maint <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 83001000003850 - Reclass From  
 (0 x 70% = 0)  
 Page 4 line 38 - Reclass to

Page 3 Line 14 col 01 & 03

Salaries - Other Non-worked-Transport Non-Emergency-Driver 710000700207000 (222) Reclass From  
 Res/Client Transportation<>Default<>Prod<>Transport Non<>Emergency 810004000003850 (2,994) Reclass From  
 Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport Non<>Emergen 730012000003850 - Reclass From  
 (\$3,216 multiplied by 70% & 30% = 70% is Medical 30% is Activities) (3,216) total

Activities - Page 3 line 11 965 Reclass to  
 Medical - Page 4 line 38 2,251 Reclass to

Page 4 Line 35 Rent col 03

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 841005000003850 - Reclass From  
 (146 x 70% = 102 lease for Medical)  
 Page 4 line 38 - Reclass to

Facility Name &amp; ID Number

Westchester Health &amp; Rehab Ctr

#0047373

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	
	<b>D. Ownership</b>											
30	Depreciation			68,522	68,522		68,522		68,522			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(790)	(790)		(790)	53,596	52,806			32
33	Real Estate Taxes			294,879	294,879		294,879	(14,296)	280,583			33
34	Rent-Facility & Grounds			531,541	531,541		531,541		531,541			34
35	Rent-Equipment & Vehicles							20,915	20,915			35
36	Other (specify):*							21,678	21,678			36
37	<b>TOTAL Ownership</b>			894,152	894,152		894,152	81,893	976,045			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					2,251	2,251		2,251			38
39	Ancillary Service Centers		186,982	17,345	204,327		204,327	41,130	245,457			39
40	Barber and Beauty Shops			14,618	14,618		14,618		14,618			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		186,982	97,663	284,645	2,251	286,896	41,130	328,026			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,845,064	766,992	2,903,272	7,515,328		7,515,328	(305,025)	7,210,303			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007 Page -4.1  
Ending: 12/31/2007

Facility Name & ID Number Westchester Health and Rehab # 0042374

**SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES**

**Ownership - Line 36 -Column 3**

	Amount
Fresh Start Acctg Adj <> Bankruptcy Exp Acq <> Cost Non Overhead 940101940058888	0
	-

**Ancillary Expenses - Line 43 -Column 2**

	Amount
Ancillary Cost of Goods Sold<->Default<->Prod<->Laboratory 800630000003330	0
Ancillary Supplies <> Default <> Laboratory 810041000003330	0
	0

**Ancillary Expenses - Line 43 -Column 3**

	Amount
Contract Svcs - Chgbl <> Default <> Laboratory 652000000003330	0
Contract Svcs - Chgbl <> Default <> X/Ray 652000000003332	0
Professional Services <> Nonchg<>Other Medical Professionals<->Labora 810030752993330	0
Professional Services - NonchgPhysicianX/Ray 810030752103332	0
Professional Services <> Nonchg<>Other Medical Professionals<->X/Ray 810030752993332	0
Professional Services <> Nonchg<>Medical Director<->Laboratory 810030795003330	0
Professional Services <> Nonchg<>Medical Director<->X/Ray 810030795003332	0
Professional Services Chgble <> Default <> X/Ray 652100000003332	0
Professional Services Chgble <> General / Other <> X/Ray 652100600003332	0
	-

**Rent-Facility & Grounds - Expenses- Line 34 Column 3**

Lease Expense Facility <> Realty-Default -Prod 84101100008220	83,196
Lease Expense Facility <> Default <> Realty 8410100008220	448,346
	531,542

**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	(16)	22		4
5	Telephone, TV & Radio in Resident Rooms				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				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(47,075)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(206,511)	21		24
25	Fund Raising, Advertising and Promotional				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	(531,520)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (785,122)		\$	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	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)	474,744		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 474,744		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (310,378)		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.	X		\$ 2,994	14	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 2,994		47

## Westchester Health &amp; Rehab Ctr

ID# 0047373

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Sales Taxes	\$ (120)	21	1
2	Small Balance Adjustment	0	21	2
3	Memorium/ Benevolence	(462)	21	3
4	Depreciation Reconciliation	0	30	4
5	Activities Program Receipts	0	11	5
6	Property Taxes Adjust to actual	(14,276)	33	6
7	Professional liability Insurance	(71,398)	26	7
8	Barber & beauty	0	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	(2,941)	20	10
11	Entertainment			11
12	Fresh Start	0	36	12
13	Civic Dues	0	20	13
14	Penalties	(72,200)	21	14
15	Vending receipts	1,706	21	15
16	Misc Receipts	(30)	21	16
17	Marketing Wages 70%	(34,973)	21	17
18	Marketing Bonus	0	21	18
19	Marketing Holiday	0	21	19
20	Maketing Sick	0	21	20
21	Marketing Vacation	0	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Donations/ Contributions	0	21	24
25	Legal Fees - Bankruptcy	0	21	25
26	Legal Structure Management Fees	(332,263)	21	26
27	Undocumented Travel	0	14	27
28	Interest Income	790	32	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	<b>Total</b>	(526,167)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Westchester Health &amp; Rehab Ctr

# 0047373

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	74	0	0	0	0	0	0	0	0	0	74	5
6	Maintenance	0	17,235	0	0	0	0	0	0	0	0	0	17,235	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	17,309	0	0	0	0	0	0	0	0	0	17,309	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(47,075)	0	0	0	0	0	0	0	0	0	0	(47,075)	19
20	Fees, Subscriptions & Promotions	(2,941)	3,958	0	0	0	0	0	0	0	0	0	1,017	20
21	Clerical & General Office Expenses	(644,853)	262,456	0	0	0	0	0	0	0	0	0	(382,397)	21
22	Employee Benefits & Payroll Taxes	(16)	15,097	0	0	0	0	0	0	0	0	0	15,081	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	24,298	0	0	0	0	0	0	0	0	0	24,298	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(71,398)	15,117	0	0	0	0	0	0	0	0	0	(56,281)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(766,283)	320,926	0	0	0	0	0	0	0	0	0	(445,357)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(766,283)	338,235	0	0	0	0	0	0	0	0	0	(428,048)	29

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Westchester Health &amp; Rehab Ctr

# 0047373

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	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)
	<b>D. Ownership</b>												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	790	52,806	0	0	0	0	0	0	0	0	0	53,596 32
33	Real Estate Taxes	(14,276)	(20)	0	0	0	0	0	0	0	0	0	(14,296) 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	20,915	0	0	0	0	0	0	0	0	0	20,915 35
36	Other (specify):*	0	21,678	0	0	0	0	0	0	0	0	0	21,678 36
37	<b>TOTAL Ownership</b>	<b>(13,486)</b>	<b>95,379</b>	<b>0</b>	<b>81,893 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	41,130	0	0	0	0	0	0	0	0	0	41,130 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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>41,130</b>	<b>0</b>	<b>41,130 44</b>								
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(779,769)</b>	<b>474,744</b>	<b>0</b>	<b>(305,025) 45</b>								

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	See Attachment Page 6.1		SSC Equity Holdings	Atlanta	Management

**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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	SSC Equity Holdings, LLC	100.00%	\$ 74	\$ 74 1
2	V	6 Repair & Maintenance		SSC Equity Holdings, LLC	100.00%	17,235	17,235 2
3	V	39 Professional Services		SSC Equity Holdings, LLC	100.00%	41,130	41,130 3
4	V	20 Fees, Subscriptions, Promotions		SSC Equity Holdings, LLC	100.00%	3,958	3,958 4
5	V	10 Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%		
6	V	21 Clerical & General Office Exp		SSC Equity Holdings, LLC	100.00%	262,456	262,456 6
7	V	24 Travel & Seminar		SSC Equity Holdings, LLC	100.00%	24,298	24,298 7
8	V	26 Insurance Premium		SSC Equity Holdings, LLC	100.00%	15,117	15,117 8
9	V	36 Depreciation		SSC Equity Holdings, LLC	100.00%	21,678	21,678 9
10	V	33 Taxes - Property		SSC Equity Holdings, LLC	100.00%	(20)	(20) 10
11	V	35 Rental & Leasing		SSC Equity Holdings, LLC	100.00%	20,915	20,915 11
12	V	32 Intrest Income/Expense		SSC Equity Holdings, LLC	100.00%	52,806	52,806 12
13	V	22 P/R Taxes		SSC Equity Holdings, LLC	100.00%	15,097	15,097 13
14	Total		\$			\$ 474,744	\$ * 474,744 14

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007  
Ending: 12/31/2007

Facility Name & ID Number: Westchester Health and Rehab # 0047373

Related Illinois Nursing Homes  
as of  
12/31/2007

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
------------	--------------------------------	--------------------------

SSC Equity Holdings, LLC

Montebello Healthcare Center	0047340
Nature Trail HealthCare Center	0047357
Odin HealthCare Center	0047365
Mariner Health of Westchester	0047373

Facility Name & ID Number      Westchester Health & Rehab Ctr      #      0047373      Report Period Beginning:      01/01/2007      Ending:      12/31/2007

## 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	N/A								\$	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: 01/01/2007 Ending: 2/31/2007

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

Name of Related Organization SSC Equity Holdings, LLC  
 Street Address One Ravinia Dr. Suite 1500  
 City / State / Zip Code Atlanta, GA 30346  
 Phone Number ( 770-829-5100  
 Fax Number ( 770-393-8054

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	1		\$ 74	\$	1	74	1
2	6	Repair & Maintenance	1		17,235		1	17,235	2
3	39	Professional Services	1		41,130		1	41,130	3
4	20	Fees, Subscriptions, Promotions	1		3,958		1	3,958	4
5	10	Nursing & Medical Records					1		5
6	21	Clerical & General Office Exp	1		262,456		1	262,456	6
7	24	Travel & Seminar	1		24,298		1	24,298	7
8	26	Insurance Premium	1		15,117		1	15,117	8
9	36	Depreciation	1		21,678		1	21,678	9
10	33	Taxes - Property	1		(20)		1	(20)	10
11	35	Rental & Leasing	1		20,915		1	20,915	11
12	32	Intrest Income/Expense	1		52,806		1	52,806	12
13	22	P/R Taxes	1		15,097		1	15,097	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				\$ 474,744	\$		\$ 474,744	25

Facility Name & ID Number Westchester Health & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

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

**B. Real Estate Taxes**

		<b>Important</b> , 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 2006 report.		\$ 139,726	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.)		\$ 280,603	2	
3.	Under or (over) accrual (line 2 minus line 1).		\$ 140,877	3	
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 154,002	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6	
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 294,879	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2002	272,141	8	
		2003	254,429	9	
		2004	266,504	10	
		2005	279,350	11	
		2006	280,603	12	
<b>FOR BHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2006 \$		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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2006 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 Lee Grigsby

TELEPHONE 832-467-6244 FAX #: 832-467-6246

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

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of total 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-29-300-018-0000</u>	<u>2901 S. Wolf Rd. Westchester</u>	<u>\$ 280,603.31</u>	<u>\$ 280,603.31</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ <u>280,603.31</u></b>	<b>\$ <u>280,603.31</u></b>

**B. Real Estate Tax Cost Allocation:**

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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:01/01/2007 Ending: 12/31/2007**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 37,531 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. 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 ground (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/AF. 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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>37,531</u>	<u>1989</u>	<u>\$ 795,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>37,531</u>		<u>\$ 795,000</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	1989	1989	\$ 4,412,330	\$ 110,308	40	\$ 110,308	\$	\$ 1,323,697
5		1991	1991	217,404	5,435	40	5,435		65,220
6		1993	1993	15,459	386	40	386		4,633
7		1994	1994	14,498	1,216	40	1,216		14,591
8		1995	1995	2,902	73	40	73		875
<b>Improvement Type**</b>									
9	Tile		1996	2,092	53	40	53		598
10	Caparting		1996	2,118	303	7	303		3,418
11	Drywall		1996	1,200	30	40	30		354
12	Building IMP/APCO		1996	4,439	111	40	111		1,295
13	Booster Heater Upgrade		1996	2,810	401	7	401		4,646
14	Repair of washer		1996	1,671	239	7	239		2,728
15	Plumbing Repair		1996	5,328	761	7	761		8,522
16	Healthcare Design		1997	6,896	172	40	172		1,764
17	Wallcoverings		1997	55,860	1,395	40	1,395		14,167
18	Draperies		1997	66,932	7,003	7	7,003		95,618
19	Painting & Decorating		1997	14,813	372	40	372		3,780
20	Carpeting		1997	38,524	5,505	7	5,505		56,406
21	Building Interior Design - Nrsng & Therapy Rooms		1997	50,274	1,257	40	1,257		12,885
22	Phone System		1998	33,091	6,618	5	6,618		64,526
23	Building Interior Design - Nrsng & Therapy Rooms		1998	52,903	1,323	40	1,323		12,826
24	Construction & Renovation - Nrsng & Therapy Rooms		1998	139,140	349	40	349		18,937
25	Heat Air Units		1998	2,239	320	7	320		2,853
26	Heat Air Units		1998	1,120	160	7	160		1,587
27	Window Treatments		1998	1,518	217	7	217		2,098
28	Cubicle Curtains		1998	1,180	169	7	169		1,563
29									
30									
31									
32									
33									
34									
35									
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 &amp; ID Number Westchester Health &amp; Rehab Ctr

# 0047373

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-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	Heat Exchange Install	1999	\$ 748	\$ 19	40	\$ 19	\$	\$ 767	37
38	Heat Exchange Install	1999	6,223	156	40	156		6,380	38
39	Interior Design Serv	1999	150	4	40	4		155	39
40	Flooring -Dining Room #420 & 421	2000	1,065	106	10	106		815	40
41	Flooring -Resident Rooms #422 & 423	2000	2,127	213	10	213		1,632	41
42	Vinyl Tile Resident #426	2000	4,004	400	10	400		3,069	42
43	Vinyl Tile Dining #427	2000	2,064	206	10	206		1,581	43
44	Vinyl Flooring # 432	2000	1,136	227	5	227		1,646	44
45	VCT W/ Wallbase #437	2000	2,650	265	10	265		1,921	45
46	Zone Air HVAC Unit, PT Rm 225 #441	2001	1,850	123	15	123		873	46
47	3: Zoneline HVAC Units #442	2001	5,700	380	15	380		2,628	47
48	3: A/C Compressor, RM 16A.& B, Rm 17A # 445	2001	5,700	380	15	380		2,502	48
49	Rooftop Condenser Coil- Kitchen #446	2001	3,880	259	15	259		1,661	49
50	Rpr Compressor, Leaks -F/A System # 447	2001	3,800	380	10	380		2,407	50
51	Roof Repair - Kitchen & Rm 226 #448	2001	833	83	10	83		527	51
52									52
53	Replc Transfer Switch/Generator #462	2002	3,100	155	20	155		904	53
54	Restore/ Clean Concrete Ramps #5003	2002	3,650	177	15	177		1,017	54
55	Zoneline Heat/Cool Unit & Use Tax #5009 & 5010	2002	759	152	5	152		835	55
56	A.O. Smith Water Heater -Instl #5017	2002	5,800	580	10	580		3,142	56
57	Compressor Repr -A/C #5020	2002	2,837	189	15	189		1,041	57
58	12: Door Closers Instl #5027	2002	4,605	307	15	307		1,663	58
59	R Carpet w/Tile (1/3 Deposit) #5032	2002	12,526	1,253	10	1,253		6,786	59
60	Roof Rep (Bal Due) #5035	2002	4,388	439	10	439		2,670	60
61	Vinyl Tile Entry Corridor (25% pmt) #5040	2002	7,000	700	10	700		3,617	61
62	Floor tile Instl -corridor (2nd pmt) #5042	2002	11,000	1,100	10	1,100		5,683	62
63	Credit - W/G Equipment #5043	2002	(250)	(25)	10	(25)		(129)	63
64	2: Repeaters # 5044	2002	1,125	112	10	112		585	64
65	Credit - W/G Discount #5045	2002	(173)	(17)	10	(17)		(87)	65
66	Wanderguard system Instl #5046	2002	46,819	4,682	10	4,682		14,826	66
67	Tile Flooring (pmt #3) #5047	2002	5,000	500	10	500		2,542	67
68	Flooring Project (Final Pmt)	2002	3,304	358	10	358		1,432	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,300,158	\$ 158,038		\$ 158,038	\$	\$ 1,794,677	70

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

STATE OF ILLINOIS

Facility Name & ID Number Westchester Health & Rehab Ctr

# 0047373

Report Period Beginning:

Page 12B  
01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 5,300,158	\$ 158,038		\$ 158,038		\$ 1,794,677		1
2	Rprs fire Sprinkler -Atic # 5048	4,300	172	25	172		831		2
3	Sprinkler System Rplc Accelerator # 5054	20,200	808	25	808		3,771		3
4	6: Sleeve/Grille -PTAC Unit #5055	571	114	5	114		513		4
5	6: PTAC Units # 5056	3,261	652	5	652		2,934		5
6	Use Tax 6: PTAC Units # 5057	23	5	5	5		22		6
7	Rplc Shingle Roof # 5058	166,000	16,600	10	16,600		73,317		7
8	Rplc Shingle Roof # 5059	46,900	4,690	10	4,690		20,714		8
9	New Split A/C Svst -Admn Office # 5065	21,500	2,150	10	2,150		9,675		9
10	Rpr Freezer #5068	2,744	183	15	183		778		10
11	Rpr Furnace (service Value core) # 5069	2,131	213	10	213		959		11
12	R Condenser Unit Admin office #5070	2,200	147	15	147		649		12
13	HVAC Repair #5071	4,246	283	15	283		1,250		13
14									14
15	RM Oxygen Room	12,457	830	15	830		3,320		15
16	I3:thru Wall A/C Units	7,609	888	5	888		3,552		16
17	I3:Instl Charge Only A/C Units	4,120	206	10	206		824		17
18	New Furnace 14-B Area	5,690	284	15	284		5,690		18
19	New Furnace 14-A & 11 Area	8,990	449	15	449		9,439		19
20	Evaporator Coil/Consensing Unit	15,989	977	15	977		16,966		20
21	Asphalt-N Driveway	23,550	2,208	8	2,208		25,758		21
22	"R" "C" Sold to SMV	2,809	258	15	258		3,068		22
23	"R" "C" Sold to SMV	3,158	263	10	263		3,421		23
24						0			24
25						(0)			25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,658,607	\$ 190,418		\$ 190,418	\$ 0	\$ 1,982,128		34

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

Facility Name &amp; ID Number Westchester Health &amp; Rehab Ctr

# 0047373

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-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		\$ 5,658,607	\$ 190,418		\$ 190,418	\$ 0	\$ 1,982,128	1
2	Instl Door w/Closer, Exit Devic	2005	2,680	74	15	74	(0)	222	2
3	Dry Sprinkler System Repair	2005	2,218	44	25	44		280	3
4	Rpr Dry Sprinkler Syst	2005	1,938	32	25	32	(0)	96	4
5	Heat Pump	2005	1,305	36	15	36		108	5
6	Double Swing Gate-Dumpsterl	2005	1,308	55	8	55		165	6
7	Heat Shower Room	2005	20,876	696	10	696		2,088	7
8	Concrete Sidewalk-1/3 Downpayment	2005	1,628	54	15	54		162	8
9	Concrete Sidewalk	2005	3,389	75	15	75		225	9
10	Plumbing Project	2005	4,750	139	20	139		417	10
11	"R" "C" Rev Use Tax	2005	368		20				11
12	Plumbing Repairs	2005	10,000	292	20	292		876	12
13	Instl Door w/Closer, Exit Devic	2005	2,576	43	15	43		129	13
14	Dry Sprinkler System Repair	2005	2,159	22	25	22		66	14
15	Rpr Dry Sprinkler Svst	2005	1,893	19	25	19		57	15
16	Heat Pump	2005	1,255	21	15	21		63	16
17	Double Swing Gate-Dumpster	2005	1,226	38	8	38		114	17
18	Heat Shower Room	2005	19,832	496	10	496		1,488	18
19	Remove Carpet & Install Tile	2005	37,384	3,738	10	3,738	(0)	11,214	19
20									20
21	Emergency Generator	2006	2,907	280	11	280		560	21
22	Paint Project - Deposit	2006	4,700	1,018	5	1,018		2,037	22
23	16:2" Wood Blinds	2006	1,647	275	5	275		549	23
24	Front Automatic Doors - 50% Deposit	2006	7,122	594	10	594		1,187	24
25	13: Cubicle Curtains W/Mesh	2006	2,037	306	5	306		611	25
26	Single Rod Valances	2006	1,623	244	5	244		487	26
27	Paint & Light Fixtures	2006	7,050	504	11	504		504	27
28	16: Wood Blinds	2006	1,718	315	5	315		630	28
29	15: Cubicle Curtains W/Mesh	2006	2,157	360	5	360		719	29
30	16: Single Rod Pocket Valances	2006	1,631	272	5	272		544	30
31	Painting of Patient Room-2nd	2006	3,889	518	5	518		1,037	31
32	Painting Facility - Down Payment	2006	4,000	533	5	533		1,067	32
33	Paint & Light Fixture	2006	3,889	518	5	518		1,037	33
34	TOTAL (lines 1 thru 33)		\$ 5,819,764	\$ 202,028		\$ 202,027	\$ (1)	\$ 2,010,865	34

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

Facility Name &amp; ID Number Westchester Health &amp; Rehab Ctr

# 0047373

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-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	\$ 5,819,764	\$ 202,028		\$ 202,027	\$ (1)	\$ 2,010,865		1
2	Painting Residents Rooms	2006 4,400	440	5	440		880		2
3	New Carpet/Admissions Office	2006 4,737	553	5	553		1,105		3
4	New Carpet/Admissions Office	2006 148	17	5	17		35		4
5	Repair Fire Alarm System	2006 1,778	148	10	148		296		5
6	Cove Base Refurb	2006 2,462	328	5	328		657		6
7	Use Tax-Cov Base/Refurb	2006 171	23	5	23		46		7
8	Painting Residents Rooms Balance	2006 6,700	670	5	670		1,340		8
9	Paint for Refurb	2006 637	53	5	53		106		9
10	Paint for Refurb	2006 499	50	5	50		100		10
11	Paint for Refurb	2006 360	36	5	36		72		11
12	Crash Rails	2006 550	27	10	27		54		12
13	Crash Rails for Walls	2006 2,961	190	10	190		379		13
14									14
15	Remodel North & South Front EX	2007 1,049	108	9.7	108	0	108		15
16	Heat/Cool Unit	2007 959	106	9.8	106		106		16
17	Connect Kit Heat/ AC Unit	2007 46	5	9.8	5		5		17
18	Oxygen Concentrators	2007 15,536	1,593	9.7	1,593	(0)	1,593		18
19	Oxygen Concentrators	2007 1,204	123	9.7	123		123		19
20	Connection Kit Heat / Cool Unit	2007 46	5	9.8	5		5		20
21	2 connect Kits Heat / AC Units	2007 92	10	9.8	10		10		21
22	Credit on Heat / AC Unit	2007 (891)	(91)	9.7	(91)		(91)		22
23	4 Heat/Cool units	2007 3,564	393	9.8	393	0	393		23
24	4 Power Conn kits heat/AC unit	2007 200	22	9.8	22		22		24
25	Furnace Repair	2007 1,380	152	9.8	152	(0)	152		25
26	Boiler Repair	2007 661	68	9.7	68		68		26
27	Remodel North & Southwest Exits	2007 53,930	4,690	9.5	4,690		4,690		27
28	Water Heater	2007 1,866	191	9.7	191	(0)	191		28
29	13 Wall Boxes/Sconce Lights	2007 290							29
30	Carpet/Labor	2007 4,440							30
31	Front Automatic Doors	2007 7,122							31
32	0: Overbed Lights	2007 1,819							32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,938,481	\$ 211,937		\$ 211,936	\$ (1)	\$ 2,023,308		34

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

STATE OF ILLINOIS

Facility Name & ID Number Westchester Health & Rehab Ctr

# 0047373

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 5,938,481	\$ 211,937		\$ 211,936	\$ (1)	\$ 2,023,308	1
2									2
3	59: Wall Boxes/Sconce Lights	2007	1,802	240	7.5	240	(0)	240	3
4	Repair Walk In Freezer	2007	5,177	566	9.15	566	0	566	4
5	Fire Sprinkler Repair	2007	2,826	309	9.15	309		309	5
6	Design Fee	2007	3,125	387	8	387	(0)	387	6
7	50: Overbed Lights / Wall Sconce	2007	9,236	1,211	7.6	1,211	(0)	1,211	7
8	61 Mount Wall Box Sconces	2007	1,876	205	9.15	205	0	205	8
9	Heat Repair	2007	3,033	607	5	607	0	607	9
10	Repair 8 Heat AC Unit	2007	11,700	2,340	5	2,340		2,340	10
11	AC Unit	2007	5,209	695	7.5	695	0	695	11
12	Stainless Steel End Wall Kitchen	2007	1,261	78	16.16	78	(0)	78	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	TOTAL (lines 1 thru 33)		\$ 5,983,727	\$ 218,574		\$ 218,574	\$ (1)	\$ 2,029,946	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,014,741	\$ 91,071	\$ 91,071	\$ (0)		\$ 762,066	71
72	Current Year Purchases	73,991	7,716	7,716			7,716	72
73	Fully Depreciated Assets	(80,911)						73
74								74
75	TOTALS	\$ 1,007,821	\$ 98,787	\$ 98,787	\$ (0)		\$ 769,782	75

D. Vehicle Depreciation (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)	\$ 7,786,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 317,361	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,522	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,799,728	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO  
 If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	120	01/01/2005	\$ 531,541	20		3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	120		\$ 531,541			7

10. Effective dates of current rental agreement:

Beginning 01/01/2005  
 Ending 12/31/2024

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ <u>                    </u>
13.	<u>/2009</u>	\$ <u>                    </u>
14.	<u>/2010</u>	\$ <u>                    </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: \$ 21,287 Description: See Attachment 14.1  
 (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	<b>TOTAL</b>		\$	\$	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.

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007

Page -14.1

Facility Name & ID Number

Westchester Health and Rehab

# 0042374

Ending: 12/31/2007

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount	Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	84100000001011	Specialty Mattress/ Beds	14,311.00	03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	84100000002022	Concentrators		03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	84100000002102			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	84100000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	84100000007030	Diswasher	854.00	03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeeping / Janitorial	84100000007040			03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	84100000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admin/Supv	84100000008000	Mattress		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	84100000008100	Copies, Stamp machine Cable	6,122.00	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plant	84100000008210	SNF Supplies		03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	84100000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	84102000008100			03/21/03
			21,287.00 Grand Total	

**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?</p> <p style="text-align: right;"> <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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)		Units	Cost							
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	10a - 03	3716	hrs	\$	144,546					\$	3,716	\$	144,546	1
2	Licensed Speech and Language Development Therapist	10a - 03	1953	hrs		101,973						1,953		101,973	2
3	Licensed Recreational Therapist	10a - 03		hrs											3
4	Licensed Physical Therapist	10a - 03	6545	hrs		253,184						6,545		253,184	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 prescripts							186,982			186,982	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs											10
11	Academic Education			hrs											11
12	Exceptional Care Program														12
13	Other (specify):														13
14	<b>TOTAL</b>				\$	499,703		\$		\$	186,982	12,214	\$	686,685	14

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

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Westchester Health &amp; Rehab Ctr

# 0047373

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 300	1
2	Cash-Patient Deposits	136,515	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	(247,395)	3
4	Supply Inventory (priced at )		4
5	Short-Term Investments		5
6	Prepaid Insurance	1,207	6
7	Other Prepaid Expenses	129,145	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 19,772	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	54,749	12
13	Land		13
14	Buildings, at Historical Cost		14
15	Leasehold Improvements, at Historical Cost	309,601	15
16	Equipment, at Historical Cost	206,169	16
17	Accumulated Depreciation (book methods)	(93,851)	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):	56,261	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 532,929	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 552,701	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 289,584	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	311,017	30
31	Accrued Taxes Payable (excluding real estate taxes)	(40)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	293,620	32
33	Accrued Interest Payable		33
34	Deferred Compensation	67,437	34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	See Schedule 17.1	96,120	36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,057,738	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43	See Schedule 17.1	505,880	43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 505,880	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,563,618	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,010,917)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 552,701	48

\*(See instructions.)

STATE OF ILLINOIS

Report Period Beginning: 1/1/2007 Page -17.1

Facility Name & ID Number Westchester Health and Rehab # 0042374

Ending: 12/31/2007

SUPPLEMENTAL SCHEDULE OF ASSETS & LIABILITIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>
		Benefits Dedctns - EmployeeEmployee Dedctns 401K Marin 201400201460000	0.00 17 36-1
		Misc Dedctns - EmployeeFlexible Spending AccountDefault- 201500201510000	0.00
		Misc Dedctns - EmployeeUnion DuesDefault-Dept 201500201520000	0.00
		Misc Dedctns - EmployeeMiscellaneousDefault-Dept 201500201530000	0.00
		Accrued OtherAccrued OtherDefault-Dept 221000221220000	66.30
		Accrued OtherAccrued OtherDefaultCMP 221000260600000	72,200.00
		Accrued OtherPC Maintenance AccrualDefault-Dept 221000221040000	0.00
		Accrued OtherAccrued Legal FeesDefault-Dept 221000221230000	19,343.11
		Accrued OtherTelephone Maintenance AccrualDefault-Dept 221000221280000	0.00
		Accrued OtherEngineering ReserveDefault-Dept 221000221420000	0.00
		Accrued TaxesOther TaxesDefault-Dept 220100220110000	0.00
		Accrued TaxesState Sales & UseDefault-Dept 220100220130000	3,117.64
		Accrued TaxesCity Sales & UseDefault-Dept 220100220140000	1,592.64
		Franchise Tax PayableFranchise TaxDefault-Dept 226200226200000	(200.00)

Total 0 Difference

Reconcile with schedule XV, line 9:

OTHER NON-CURRENT ASSETS: pg 17 line 23 Col 1

Other Assets <- Rfndable Deposits-Non Int Brg <- Defal 184000184030000 54,749

Total 54,749 Difference

Reconcile with schedule XV, line 23:

Total 96,120 Difference

Reconcile with schedule XV, line 36:

OTHER NON-CURRENT LIABILITIES::

I/C - Interunit Asset Transfer-Default-Dept-Default-Prod 240500000000000	(401,089) 17 43-1
Intercompany Revolver - SSC-Default-Dept-Default-Prod 260000210140000	126,261
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Clair 260000210160000	105,049
Other Non-Current Lby-Default-Dept-Deferred CLO Gain/Loss 260500225030000	533,873
Other Non-Current Lby <-> Rent Accrual <-> Default 260500260540000	141,786

Total 505,880 Difference

Reconcile with schedule XV, line 43:

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,575,515	1
2	Restatements (describe):		2
3	Adjust PY Intercompany	(4,738,479)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (162,964)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(847,953)	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)	\$ (847,953)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,010,917)	24 *

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number Westchester Health &amp; Rehab Ctr

# 0047373

Report Period Beginning: 01/01/2007

Ending:

Page 19

12/31/2007

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,407,814	1
2	Discounts and Allowances for all Levels	(4,301,311)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,106,503	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,099,963	6
7	Oxygen	2,078	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,102,041	8
<b>C. Other Operating Revenue</b>			
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	19,375	13
14	Non-Patient Meals	1,084	14
15	Telephone, Television and Radio	(19)	15
16	Rental of Facility Space		16
17	Sale of Drugs	352,496	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,242	19
20	Radiology and X-Ray	7,714	20
21	Other Medical Services	52,260	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 457,152	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc Receipts See Sch pg 19.1	711	28
28a	Misc Receipts Activities See Sch pg 19.1	965	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,675	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,667,371	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,011,674	31
32	Health Care	3,368,216	32
33	General Administration	1,956,641	33
<b>B. Capital Expense</b>			
34	Ownership	894,152	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	284,645	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,515,327	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(847,956)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (847,956)	43

\* 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.

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007 Page -19.1  
Ending: 12/31/2007

Facility Name & ID Number Westchester Health and Rehab # 0042374

**SUPPLEMENATAL INCOME SCHEDULE**

<u>DESCRIPTION - Line 19 26a 1 &amp; 19 28 1</u>		<u>AMOUNT</u>	
Miscellaneous Receipts<-Default<->Prod<->Administrative	600057000008100	(995)	
General Rental Receipts<-Default<->Prod<->Administrative	600060000008100		
Miscellaneous Receipts<-Default<->Prod<->Vending	600057000004102	1,706	
	Total	711.00	Difference
Reconcile with schedule XVII, line 28:		711	0

<u>DESCRIPTIONS - Line 19 28a 1</u>			
Miscellaneous Receipts<-Default<->Prod<->Activities	600057000007000	965	
	Total	965	Difference
Reconcile with schedule XVII, line 28a:		965	-

Facility Name & ID Number Westchester Health & Rehab Ctr

# 0047373

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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	1,072	1,241	\$ 43,278	\$ 34.87	1
2	Assistant Director of Nursing	1,216	1,386	44,380	32.02	2
3	Registered Nurses	14,191	15,051	476,478	31.66	3
4	Licensed Practical Nurses	25,831	28,111	761,255	27.08	4
5	CNAs & Orderlies	70,049	76,387	900,813	11.79	5
6	CNA Trainees					6
7	Licensed Therapist	13,096	14,061	530,986	37.76	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,889	2,089	34,382	16.46	9
10	Activity Assistants	4,517	4,875	47,180	9.68	10
11	Social Service Workers	1,942	2,956	64,615	21.86	11
12	Dietician					12
13	Food Service Supervisor	1,910	2,086	46,732	22.40	13
14	Head Cook	6,089	6,600	87,493	13.26	14
15	Cook Helpers/Assistants	12,296	13,528	108,938	8.05	15
16	Dishwashers					16
17	Maintenance Workers	834	3,011	50,735	16.85	17
18	Housekeepers	13,528	14,917	152,581	10.23	18
19	Laundry	5,250	5,593	54,923	9.82	19
20	Administrator	2,032	2,088	97,018	46.46	20
21	Assistant Administrator					21
22	Other Administrative	10,576	11,390	272,041	23.88	22
23	Office Manager					23
24	Clerical	4,263	4,708	56,460	11.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,018	1,018	14,775	14.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,599	211,096	\$ 3,845,063 *	\$ 18.21	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	1,560	\$ 18,750	1-3	35
36	Medical Director	96	16,800	9-3	36
37	Medical Records Consultant	72	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	3,514	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	4,949	11-3	44
45	Social Service Consultant	36	2,976	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,824	\$ 51,213		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





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 Healthcare Association \$6,985.71
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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. \$ 39,367 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. N/A
- (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. \$ 65,700  
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 benefit: on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
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. \$ N/A  
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? \_\_\_\_\_  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.