



Facility Name & ID Number Westchester Health & Rehab Center

# 0047373 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	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	<u>23,646</u>	<u>5,262</u>	<u>6,822</u>	<u>35,730</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,646</u>	<u>5,262</u>	<u>6,822</u>	<u>35,730</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.35%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
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 01/01/2008

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 6,118

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Westchester Health & Rehab Center # 0047373 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	252,737	20,472	17,314	290,523		290,523		290,523		1
2	Food Purchase		169,834		169,834		169,834	(46)	169,788		2
3	Housekeeping	163,323	14,200		177,523		177,523		177,523		3
4	Laundry	51,917	8,360		60,277		60,277		60,277		4
5	Heat and Other Utilities			208,213	208,213		208,213	(11,019)	197,194		5
6	Maintenance	25,280	78,590	15,492	119,362		119,362	15,472	134,834		6
7	Other (specify):*			30,739	30,739		30,739		30,739		7
8	<b>TOTAL General Services</b>	493,257	291,456	271,758	1,056,471		1,056,471	4,407	1,060,878		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,255,095	172,515	334,497	2,762,107		2,762,107		2,762,107		10
10a	Therapy	412,088	82,866	24,347	519,301		519,301		519,301		10a
11	Activities	89,202	4,089	3,911	97,202		97,202		97,202		11
12	Social Services	64,819		2,564	67,383		67,383		67,383		12
13	CNA Training										13
14	Program Transportation			203	203		203		203		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,821,204	259,470	389,522	3,470,196		3,470,196		3,470,196		16
	<b>C. General Administration</b>										
17	Administrative	77,044			77,044	40,796	117,840		117,840		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			124,919	124,919	(40,796)	84,123		84,123		19
20	Dues, Fees, Subscriptions & Promotions			70,323	70,323		70,323	(13,272)	57,051		20
21	Clerical & General Office Expenses	357,750	23,906	578,172	959,828		959,828	(101,278)	858,550		21
22	Employee Benefits & Payroll Taxes			559,812	559,812		559,812	17,483	577,295		22
23	Inservice Training & Education			2,911	2,911		2,911		2,911		23
24	Travel and Seminar			5,819	5,819		5,819	35,452	41,271		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			86,809	86,809		86,809	9,880	96,689		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	434,794	23,906	1,429,265	1,887,965		1,887,965	(51,735)	1,836,230		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,749,255	574,832	2,090,545	6,414,632		6,414,632	(47,328)	6,367,304		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.

STATE OF ILLINOIS

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

Facility Name & ID Number +Facility # 0039586

**Meals - adjustment**

35,730 Days ( Total Patient days)  
3 Mult (3 meals a day)  
107,190 Sub total  
29 meals to employess (reported by facility)  
107,219 Add Sub  
169,834 Divide -Pg 3, line 2, column 2  
1.58 Cost per day

**Sales Tax - adjustment**

169,834 Total Food Cost (page 3,Line 2, col 2)  
1.01  
0.01 Mult  
1,681.52 Sub total  
7.36% Mult (Pvt pay div by total census)  
62 = adjust for nonallowable sale tax  
for page 5A, Line 13

1.58 Cost per day  
29 mult - meal to employees  
45.94 = adjust for pg 3, line 2, column7

Personal Cable TV - in patient rooms

86004000004100 11,019

**Reclassification V**

Page 3 Line 6 col 01

Repair & Maint <> Vehicles<>Default<>Prod<>Transp 830010000003850 - Reclass From  
70%  
0  
Page 4 line 38 - Reclass to

Page 3 Line 14 col 01

Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 - Reclass From  
Salaries Overtime/DbI Time<>Driver<>Transport Non<>Emergenc 700500750403850 - Reclass From  
Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport N 730012000003850 - Reclass From  
(0 x 70% & 30%) 70% is Medical 30% is activities - total

Activities Page 3 line 11 - Reclass to  
Medical Page 4 line 38 - Reclass to  
-

Page 4 Line 35 Rent col 03

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emer 841005000003850 - Reclass From  
(0 x 70% = 0 lease for Medical)  
Page 4 line 38 - Reclass to

Page 3 Line 19 Col 3

Consulting / Prof Svcs-Administrative-Administrator 810020701008100 40,796 Reclass to Line Page 3 Line 17  
Reclass to Page 3, Line 17, Col 3

STATE OF ILLINOIS

Report Period:

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

Page -3.1

Facility Name & ID Number Nature Trail Healthcare Center # 0039586

**SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES**

**Operating Expense - pg 3 Line 7**

**Amount**

Infectious Waste Disposal <> Default <> Nursing Admin/Supv	800019000008000	11,327
Infectious Waste Disposal <> Default <> Physical Plant	800019000008210	0
Garbage Service<>Default<>Prod<>Physical Plant	810002000008210	19,412
Garbage Service <> Default <> Physical Plant	810072000008210	0
		<u>30,739</u>

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

**Amount**

Salaries - Regular <> Non Supervisor <> HHA (General)	700000700203500	0
		<u>0</u>

**General & Administrative - Line 27**

**Amount**

N/A		
		<u>0</u>

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

**Amount**

**Back Office Services Fees - Admin - Pg 3, Line 21**

**Amount**

92710000008100	355,689
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Facility Name & ID Number Westchester Health & Rehab Center

#0047373

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

12/31/2008

## 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			76,540	76,540		76,540	(6,310)	70,230			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,834)	(1,834)		(1,834)	39,050	37,216			32
33	Real Estate Taxes			286,179	286,179		286,179	835	287,014			33
34	Rent-Facility & Grounds			531,541	531,541		531,541		531,541			34
35	Rent-Equipment & Vehicles			10,779	10,779		10,779	16,975	27,754			35
36	Other (specify):*							34,388	34,388			36
37	<b>TOTAL Ownership</b>			903,205	903,205		903,205	84,938	988,143			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		153,984	11,966	165,950		165,950	39,961	205,911			39
40	Barber and Beauty Shops			14,438	14,438		14,438		14,438			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*		250		250		250		250			43
44	<b>TOTAL Special Cost Centers</b>		154,234	92,284	246,518		246,518	39,961	286,479			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,749,255	729,066	3,086,034	7,564,355		7,564,355	77,571	7,641,926			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 Center

# 0047373

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	(46)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,019)	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				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	6,276	21		18
19	Entertainment	(28)	24		19
20	Contributions	(150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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	(5,529)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (10,496)		\$	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)	498,533		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 498,533		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 488,037		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Westchester Health & Rehab Center

ID# 0047373

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salary Expense (70% Disallowed)	\$ (40,724)	21	1
2	Back Office Management Fee	(355,689)	21	2
3	Non Allowable Advertising	(7,743)	20	3
4	Adjust Depreciation to Historical	(6,310)	30	4
5				5
6				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				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>	(410,466)		49

## STATE OF ILLINOIS

Summary A

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

# 0047373

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	(46)	0	0	0	0	0	0	0	0	0	0	(46)	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	(11,019)	0	0	0	0	0	0	0	0	0	0	(11,019)	5
6	Maintenance	0	15,472	0	0	0	0	0	0	0	0	0	15,472	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(11,065)</b>	<b>15,472</b>	<b>0</b>	<b>4,407</b>	<b>8</b>								
	<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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,272)	0	0	0	0	0	0	0	0	0	0	(13,272)	20
21	Clerical & General Office Expenses	(390,287)	289,009	0	0	0	0	0	0	0	0	0	(101,278)	21
22	Employee Benefits & Payroll Taxes	0	17,483	0	0	0	0	0	0	0	0	0	17,483	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(28)	35,480	0	0	0	0	0	0	0	0	0	35,452	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,880	0	0	0	0	0	0	0	0	0	9,880	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(403,587)</b>	<b>351,852</b>	<b>0</b>	<b>(51,735)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(414,652)</b>	<b>367,324</b>	<b>0</b>	<b>(47,328)</b>	<b>29</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 Listing on Page 6.1				

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%			1	
2	V	6	Repair and Maintenance	SSC Equity Holdings, LLC	100.00%		15,472	2	
3	V	39	Professional Services	SSC Equity Holdings, LLC	100.00%		39,961	3	
4	V	20	Fees, Subscriptions and Dues	SSC Equity Holdings, LLC	100.00%			4	
5	V	10	Nursing and Medical Records	SSC Equity Holdings, LLC	100.00%			5	
6	V	21	Clerical & Gen Office Exp	SSC Equity Holdings, LLC	100.00%		289,009	6	
7	V	24	Travel and Seminar	SSC Equity Holdings, LLC	100.00%		35,480	7	
8	V	26	Insurance	SSC Equity Holdings, LLC	100.00%		9,880	8	
9	V	36	Depreciation	SSC Equity Holdings, LLC	100.00%		34,388	9	
10	V	33	Taxes - Property	SSC Equity Holdings, LLC	100.00%		835	10	
11	V	35	Rental and Leasing	SSC Equity Holdings, LLC	100.00%		16,975	11	
12	V	32	Interest Income/Expense	SSC Equity Holdings, LLC	100.00%		39,050	12	
13	V	22	Payroll Taxes	SSC Equity Holdings, LLC	100.00%		17,483	13	
14	Total		\$			\$	\$ *	498,533	14

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

**Related Illinois Nursing Homes  
as of 12/31/2008**

<b>Group Name</b>	<b>Related Illinois Nursing Homes</b>	<b>Illinois Facility Number</b>
SSC Equity Holdings, LLC	Montebello Health Care Center	6006316
	Nature Trail Health Care Center	6006498
	Odin Health Care Center	6006878
	Westchester Health Care Center	6012173

Facility Name & ID Number Westchester Health & Rehab Center # 0047373 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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 Center

# 0047373 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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 5300 W Sam Houston Prkwy North, Ste100  
 City / State / Zip Code Houston, TX 77041  
 Phone Number ( 832)467-6000  
 Fax Number ( 832)467-6114

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	<u>5</u>	<u>Utilities</u>			\$	\$		\$	1
2	<u>6</u>	<u>Repair and Maintenance</u>						15,472	2
3	<u>39</u>	<u>Professional Services</u>						39,961	3
4	<u>20</u>	<u>Fees, Subscriptions and Dues</u>							4
5	<u>10</u>	<u>Nursing and Medical Records</u>							5
6	<u>21</u>	<u>Clerical &amp; Gen Office Exp</u>						289,009	6
7	<u>24</u>	<u>Travel and Seminar</u>						35,480	7
8	<u>26</u>	<u>Insurance</u>						9,880	8
9	<u>36</u>	<u>Depreciation</u>						34,388	9
10	<u>33</u>	<u>Taxes - Property</u>						835	10
11	<u>35</u>	<u>Rental and Leasing</u>						16,975	11
12	<u>32</u>	<u>Interest Income/Expense</u>						39,050	12
13	<u>22</u>	<u>Payroll Taxes</u>						17,483	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				\$	\$		\$ 498,533	25

**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							\$	\$			\$	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.)



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Westchester Health & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047373

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE (832) 467-6317 FAX #: (832) 467-6324

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

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(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</u>	<u>\$ 285,613.50</u>	<u>\$ 285,613.50</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ 285,613.50</u>	<u>\$ 285,613.50</u>

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 direct 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 hom (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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

**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.

**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).

N/A

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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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

# 0047373

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

**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		2005		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		12.5 Ton RTU - Kitchen - 50% downpayment		2005	6,484	648	10	648		2,214	9
10		Concrete Sidewalk 1/3 downpayment		2005	1,628	139	12	139		485	10
11		12.5 Ton RTU - Kitchen - Balance		2005	6,484	648	10	648		2,161	11
12		Concrete Sidewalk		2005	3,389	293	11.5	293		975	12
13		Plumbing Project		2005	4,750	401	11.8	401		1,438	13
14		Plumbing Repairs		2005	10,000	845	11.8	845		3,028	14
15		Instl Door w/Closer - Exit Device		2005	2,576	224	11.5	224		728	15
16		Mixing Valve Spout - Kitchen		2005	2,207	192	11.5	192		624	16
17		Dry Sprinkler System Repair		2005	2,159	188	11.5	188		610	17
18		Repair Dry Sprinkler System		2005	1,893	165	11.5	165		535	18
19		Heat Pump		2005	1,255	109	11.5	109		355	19
20		Double Swing Gates - Dumpster		2005	1,226	153	8	153		498	20
21		Heat - Shower Room		2005	19,832	1,983	10	1,983		6,445	21
22		Remove Carpet and Install Tile		2005	37,384	3,738	10	3,738		11,527	22
23											23
24		Emergency Generator		2006	2,907	258	11.25	258		775	24
25		Paint Project - Deposit		2006	4,700	940	5	940		2,820	25
26		16: 2" Wood Blinds		2006	1,647	329	5	329		906	26
27		Front Automatic Doors - 50% Deposit		2006	7,122	712	10	712		1,959	27
28		13: Cubicle Curtains W/Mesh		2006	2,037	407	5	407		1,086	28
29		16: Single Rod Valances		2006	1,623	325	5	325		866	29
30		Paint and Light Fixtures		2006	7,050	671	10.5	671		1,790	30
31		16: Wood Blinds		2006	1,718	344	5	344		973	31
32		15: Cubicle Curtains W/Mesh		2006	2,157	431	5	431		1,187	32
33		16: Single Rod Valances		2006	1,631	326	5	326		897	33
34		Painting Patient Rooms		2006	3,889	778	5	778		2,009	34
35		Painting Facility- Down Pmt		2006	4,000	800	5	800		2,066	35
36											36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

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

# 0047373

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## 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	Paint and Light Fixture	2006	\$ 3,889	\$ 778	5	\$ 778	\$	\$ 2,009	37
38	Painting Resident Rooms	2006	4,400	880	5	880		2,127	38
39	New Carpet - Admissions Office	2006	4,737	947	5	947		2,368	39
40	New Carpet - Admissions Office	2006	148	30	5	30		74	40
41	Repair Fire Alarm System	2006	1,778	178	10	178		489	41
42	Cove Base/Refurb	2006	2,462	492	5	492		1,272	42
43	Use Tax - Cove Base/Refurb	2006	171	34	5	34		88	43
44	Painting Resident Rooms - Balance	2006	6,700	1,340	5	1,340		3,238	44
45	Paint for Refurb	2006	637	127	5	127		297	45
46	Paint for Refurb	2006	499	100	5	100		241	46
47	Paint for Refurb	2006	360	72	5	72		174	47
48	Crash Rails	2006	550	54	10.25	54		130	48
49	Crash Rails for Walls	2006	2,961	284	10.42	284		734	49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269	27	10	27		58	51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21	2	10	2		5	52
53	Carpet/Labor	2007	4,440	888	5	888		1,998	53
54	Front Automatic Doors - Balance	2007	7,122	712	10	712		1,840	54
55	10: Overbed Lights	2007	1,689	169	10	169		394	55
56	Use Tax - 10: Overbed Lights	2007	131	13	10	13		31	56
57	59: Wall Boxes/Sconce Lights	2007	1,675	167	10	167		391	57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127	13	10	13		30	58
59	Remodel North & South Front Exit	2007	1,049	108	9.75	108		206	59
60	Heat/Cool Unit	2007	959	98	9.83	98		195	60
61	Connect Kit Heat/AC Unit	2007	46	5	9.83	5		9	61
62	Repair to Walk In Freezer	2007	5,177	522	9.92	522		1,088	62
63	Fire Sprinkler Repair	2007	2,826	285	9.92	285		594	63
64	Design Fee	2007	2,900	288	10.08	288		647	64
65	Design Fee	2007	225	22	10.08	22		50	65
66	50 Overbed Lights and Wall Sconces	2007	8,572	843	10.16	843		1,967	66
67	50 Overbed Lights and Wall Sconces	2007	664	65	10.16	65		152	67
68	61 Mount Wall Box Sconces	2007	1,741	176	9.92	176		366	68
69	61 Mount Wall Box Sconces	2007	135	14	9.92	14		28	69
70	TOTAL (lines 4 thru 69)		\$ 210,809	\$ 25,781		\$ 25,781	\$	\$ 72,250	70

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

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

# 0047373

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 210,809	\$ 25,781		\$ 25,781	\$	\$ 72,250	1
2	29 Oxygen Concentrators	2007	15,536	1,593	9.75	1,593		3,054	2
3	29 Oxygen Concentrators	2007	1,204	123	9.75	123		237	3
4	Cr: Void Ck Village Westchester	2007	(1,049)	(108)	9.75	(108)		(206)	4
5	Permit Fee to Remode;	2007	1,049	109	9.66	109		199	5
6	Connection Kit Heat/Cool Unit	2007	46	5	9.83	5		9	6
7	2 Connect Kits Heat/AC Units	2007	92	9	9.83	9		19	7
8	Cr on Heat/AC Unit	2007	(891)	(91)	9.75	(91)		(175)	8
9	4 Heat/Cool Units	2007	3,564	362	9.83	362		725	9
10	4 Power Conn Kits Heat/AC Units	2007	201	20	9.83	20		41	10
11	Furnace Repair	2007	1,380	140	9.83	140		281	11
12	Heat Repair	2007	3,033	303	10	303		910	12
13	Repair 8 Heat AC Units	2007	11,700	1,170	10	1,170		3,510	13
14	Boiler Repair	2007	661	68	9.75	68		130	14
15	Remodel North/Southwest Exits	2007	53,930	5,627	9.58	5,627		9,848	15
16	AC Unit	2007	4,835	483	10	483		1,128	16
17	AC Unit	2007	375	37	10	37		87	17
18	Water Heater	2007	1,866	191	9.75	191		367	18
19	Stainless Steel End Wall Kitchen	2007	1,261	134	9.41	134		212	19
20									20
21	2:AC Compressor Units	2008	9,874	1,512	9.25	1,512		1,512	21
22	Steel Door	2008	1,675	217	9	217		217	22
23	Furnace 50% Deposit	2008	2,759	289	8.75	289		289	23
24	Compressor For Cooling System	2008	3,993	642	9.33	642		642	24
25	Furnace -Final Payment	2008	2,759	265	8.66	265		265	25
26	Steel Door - Balance	2008	1,675	176	8.75	176		176	26
27	2: Zonline Heat/Cool Units	2008	1,341	129	8.66	129		129	27
28	Heat Exchanger for Boiler	2008	7,510	656	8.58	656		656	28
29	6: Zonline heat/Cool Units	2008	3,636	303	5	303		303	29
30	AT&T Circuit Conversion	2008	32,788	1,338	8.16	1,338		1,338	30
31	AT&T Circuit Conversion	2008	6,306	131	8	131		131	31
32	Blower Assembly	2008	3,511	73	8	73		73	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 387,429	\$ 41,691		\$ 41,691	\$	\$ 98,357	34

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

Facility Name & ID Number Westchester Health & Rehab Center # 0047373 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	\$ 206,169	\$ 25,201	\$ 25,201	\$	8	\$ 63,213	71
72	Current Year Purchases	29,347	3,337	3,337		5	3,337	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 235,517	\$ 28,538	\$ 28,538	\$		\$ 66,550	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)	\$ 622,945	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,230	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,230	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)	\$ 164,907	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: SMV Property 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>01/01/2005</u>	\$ <u>531,541</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>120</b>		\$ <b>531,541</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 01/01/2005  
Ending 12/31/2016

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/2009</u>	\$ <u>531,541</u>
13.	<u>12/2010</u>	\$ <u>531,541</u>
14.	<u>12/2011</u>	\$ <u>531,541</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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

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

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

Facility Name & ID Number Westchester Health & Rehab Center # 0047373 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10 a-1	##### hrs	\$ 102,966		\$		2,340	\$ 102,966	1
2	Licensed Speech and Language Development Therapist	10 a-1	##### hrs	51,191				1,194	51,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10 a-1	##### hrs	221,197				5,797	221,197	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				153,984		153,984	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			\$ 375,354		\$	\$ 153,984	9,331	\$ 529,338	14

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

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

# 0047373

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 300	\$	1
2	Cash-Patient Deposits	153,742		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,210,588		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	991		6
7	Other Prepaid Expenses	72,130		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>	\$ 1,437,751	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,765		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	387,429		15
16	Equipment, at Historical Cost	235,517		16
17	Accumulated Depreciation (book methods)	(164,909)		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):	49,951		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 544,753	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,982,504	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 179,040	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	313,307		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,919		31
32	Accrued Real Estate Taxes(Sch.IX-B)	285,624		32
33	Accrued Interest Payable			33
34	Deferred Compensation	67,437		34
35	Federal and State Income Taxes			35
36	<b>Other Current Liabilities(specify):</b>			
37		2,410		36
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 894,737	\$	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
43	<b>Other Long-Term Liabilities(specify):</b>			
44		2,431,960		43
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,431,960	\$	44
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,326,697	\$	45
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,344,194)	\$	46
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,982,503	\$	47

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,010,917)	1
2	Restatements (describe):		2
3	Prior Year Adjustment	100,511	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (910,406)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(433,788)	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)	\$ (433,788)	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)	\$ (1,344,194)	24 *

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

**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	\$ 9,683,951	1
2	Discounts and Allowances for all Levels	(3,711,899)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,972,052	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	871,262	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 871,262	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	20,084	13
14	Non-Patient Meals	388	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	250,390	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,760	19
20	Radiology and X-Ray	10,072	20
21	Other Medical Services	1,238	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 290,932	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 Income - Administrative	(6,707)	28
28a	Misc Income - Vending & Activities	3,028	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (3,679)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,130,567	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,056,471	31
32	Health Care	3,470,196	32
33	General Administration	1,887,965	33
<b>B. Capital Expense</b>			
34	Ownership	903,205	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	180,388	35
36	Provider Participation Fee	65,880	36
<b>D. Other Expenses (specify):</b>			
37		250	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,564,355	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(433,788)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (433,788)	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: 01/01/2008  
Ending: 12/31/2008

Facility Name & ID Number Westchester Health & Rehab Center

# 0047373

SUPPLEMENTAL SCHEDULE - OTHER INCOME

DESCRIPTION - Page 19, Line 28	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdAdministrative	600057000008100	6,707
General Rental ReceiptsDefault-ProdAdministrative	600060000008100	0
Reconcile with Schedule XVII, Line 28		6,707

DESCRIPTION - Page 19, Line 28a	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdVending	600057000004102	(2,022)
Miscellaneous ReceiptsDefault-ProdActivities	600057000007000	(1,006)
Reconcile with Schedule XVII, Line 28a		(3,028)

Facility Name & ID Number Westchester Health & Rehab Center

# 0047373

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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	560	584	\$ 26,258	\$ 44.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,884	18,181	570,407	31.37	3
4	Licensed Practical Nurses	25,864	28,151	765,082	27.18	4
5	CNAs & Orderlies	68,595	74,156	873,461	11.78	5
6	CNA Trainees					6
7	Licensed Therapist	9,659	10,378	412,088	39.71	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,905	2,101	35,191	16.75	9
10	Activity Assistants	5,249	5,580	54,011	9.68	10
11	Social Service Workers	2,720	2,890	64,819	22.43	11
12	Dietician					12
13	Food Service Supervisor	1,851	2,091	46,086	22.04	13
14	Head Cook	6,852	7,552	100,088	13.25	14
15	Cook Helpers/Assistants	11,520	12,225	106,562	8.72	15
16	Dishwashers					16
17	Maintenance Workers	1,694	1,814	25,280	13.94	17
18	Housekeepers	13,160	14,187	163,323	11.51	18
19	Laundry	4,944	5,261	51,917	9.87	19
20	Administrator	1,528	1,744	77,493	44.43	20
21	Assistant Administrator					21
22	Other Administrative	8,446	9,247	242,098	26.18	22
23	Office Manager					23
24	Clerical	6,744	7,436	115,203	15.49	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	1,376	1,376	19,888	14.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,551	204,954	\$ 3,749,255 *	\$ 18.29	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		\$ 15,680	1-3	35
36	Medical Director		24,000	9-3	36
37	Medical Records Consultant		4,320	10-3	37
38	Nurse Consultant		313,756	10-3	38
39	Pharmacist Consultant		4,048	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		120	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,656	11-3	44
45	Social Service Consultant		2,564	12-3	45
46	Other(specify)				46
47	Xray Consultants		8,332	39-3	47
48	Legal Consultant				48
49	TOTAL (lines 35 - 48)		\$ 374,476		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

Facility Name & ID Number Westchester Health & Rehab Center

# 0047373

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	
Monica I Ramirez	Administrator	0	\$ 50,735	Workers' Compensation Insurance	\$ 179,444	IDPH License Fee	\$	
Mary F Von Goeben	Administrator	0	26,309	Unemployment Compensation Insurance	57,431	Advertising: Employee Recruitment	42,450	
				FICA Taxes	273,033	Health Care Worker Background Check	4,334	
				Employee Health Insurance	36,127	(Indicate # of checks performed _____)		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		Non Allowable Advertsing	7,743	
				Life Insurance	4,133	Yellow Pages	5,529	
				Other Benefits	9,647	Dues	6,016	
						Other Licenses	1,588	
TOTAL (agree to Schedule V, line 17, col. 1)				Home Office Allocation Payroll Taxes	17,483	Subscriptions	2,663	
(List each licensed administrator separately.)			\$ 77,044			Less: Public Relations Expense ( )		
B. Administrative - Other						Non-allowable advertising	(7,743)	
Description			Amount			Yellow page advertising	(5,529)	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 577,298	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 57,051	
(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	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Essential Staffing	Temp Administrator		\$ 40,796				Out-of-State Travel	\$
Talx Corp	Unemployment Mgt		555					
Viatch Publishing	TLC Program		18					
CT Corp			234				In-State Travel	5,045
Duane Morris LLP	Legal		13,898				Meals	746
Ogeltree Deakins Nash &	Legal		46,346				Entertainment	28
Richard Lowell LLC	Legal Fees		10,000					
Sandra Gourley	Legal Settlement		12,000				Seminar Expense	
My InnerView	Surveys, Residents, Family		438				Home Office Allocation	35,480
Press Ganey	Research		16					
Illinois State Police	Resident Background Cks		368					
Secretary of State	Filing Srvc		250				Entertainment Expense	(28)
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 124,919				TOTAL	\$ 41,271

\* Attach copy of IMRF notifications

\*\*See instructions.



**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 Assn \$6,016
- (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. \$ 39,837 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,880  
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? No Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit is not completed yet
- (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.

	2014	2013	2012	2011
<b>Operating Income</b>	<b>1,234</b>	<b>1,123</b>	<b>1,012</b>	<b>901</b>
Operating Expenses	(876)	(765)	(654)	(543)
Depreciation	123	112	101	90
Amortization	45	44	43	42
Goodwill Impairment	10	10	10	10
Other Non-Operating Income	23	23	23	23
Income Tax Expense	(100)	(100)	(100)	(100)
Net Income	329	327	329	323
Other Comprehensive Income	10	10	10	10
Comprehensive Income	339	337	339	333
Basic EPS	1.23	1.12	1.01	0.90
Diluted EPS	1.12	1.01	0.90	0.80





