

Facility Name & ID Number Westchester Health & Rehabilitation Center0047373

0047373 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	26,192	4,333	7,638	38,163	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,192	4,333	7,638	38,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.13%

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 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 120 and days of care provided 6,193

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Westchester Health & Rehabilitation Center # 0047373 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	253,002	23,934	19,035	295,971		295,971		295,971		1
2	Food Purchase		192,821		192,821		192,821	(206)	192,615		2
3	Housekeeping	185,583	19,356	3,116	208,055		208,055		208,055		3
4	Laundry	53,690	11,901		65,591		65,591		65,591		4
5	Heat and Other Utilities			168,227	168,227		168,227	(12,059)	156,168		5
6	Maintenance	30,733	56,359	17,129	104,221		104,221	16,280	120,501		6
7	Other (specify):*			26,938	26,938		26,938		26,938		7
8	TOTAL General Services	523,008	304,371	234,445	1,061,824		1,061,824	4,015	1,065,839		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,358,927	155,429	97,838	2,612,194	(40)	2,612,154		2,612,154		10
10a	Therapy	410,885	59,397	111,286	581,568		581,568		581,568		10a
11	Activities	91,467	3,450	8,799	103,716		103,716		103,716		11
12	Social Services	83,800	40	1,982	85,822		85,822		85,822		12
13	CNA Training										13
14	Program Transportation			(1,126)	(1,126)		(1,126)		(1,126)		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,945,079	218,316	242,779	3,406,174	(40)	3,406,134		3,406,134		16
	C. General Administration										
17	Administrative	102,477			102,477		102,477		102,477		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			34,415	34,415		34,415	(31,300)	3,115		19
20	Dues, Fees, Subscriptions & Promotions			61,776	61,776		61,776	(2,216)	59,560		20
21	Clerical & General Office Expenses	353,688	15,354	288,110	657,152		657,152	(49,146)	608,006		21
22	Employee Benefits & Payroll Taxes			464,853	464,853		464,853	16,963	481,816		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,308	7,308		7,308	49,133	56,441		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			113,083	113,083		113,083	(48,828)	64,255		26
27	Other (specify):*										27
28	TOTAL General Administration	456,165	15,354	970,045	1,441,564		1,441,564	(65,394)	1,376,170		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,924,252	538,041	1,447,269	5,909,562	(40)	5,909,522	(61,379)	5,848,143		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			88,125	88,125		88,125		88,125			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(11,286)	(11,286)		(11,286)	33,887	22,601			32
33	Real Estate Taxes			271,862	271,862		271,862	358	272,220			33
34	Rent-Facility & Grounds			531,541	531,541		531,541		531,541			34
35	Rent-Equipment & Vehicles							17,760	17,760			35
36	Other (specify):*							24,755	24,755			36
37	TOTAL Ownership			880,242	880,242		880,242	76,760	957,002			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,112	31,216	206,328	40	206,368	17,301	223,669			39
40	Barber and Beauty Shops			17,338	17,338		17,338		17,338			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	TOTAL Special Cost Centers		175,112	114,254	289,366	40	289,406	17,301	306,707			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,924,252	713,153	2,441,765	7,079,170		7,079,170	32,682	7,111,852			45

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

Westchester Health & Rehabilitation Center

ID# 0047373

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Back Office Service Feee	\$ (379,009)	21	1
2	Professional Liability Insurance	(59,922)	26	2
3				3
4				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	Total	(438,931)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Health & Rehabilitation Center

0047373

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(206)	0	0	0	0	0	0	0	0	0	0	(206)	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	(12,059)	0	0	0	0	0	0	0	0	0	0	(12,059)	5
6	Maintenance	0	16,280	0	0	0	0	0	0	0	0	0	16,280	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,265)	16,280	0	4,015	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(31,300)	0	0	0	0	0	0	0	0	0	0	(31,300)	19
20	Fees, Subscriptions & Promotions	(3,642)	1,426	0	0	0	0	0	0	0	0	0	(2,216)	20
21	Clerical & General Office Expenses	(347,180)	298,034	0	0	0	0	0	0	0	0	0	(49,146)	21
22	Employee Benefits & Payroll Taxes	0	16,963	0	0	0	0	0	0	0	0	0	16,963	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(226)	49,359	0	0	0	0	0	0	0	0	0	49,133	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(59,922)	11,094	0	0	0	0	0	0	0	0	0	(48,828)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(442,270)	376,876	0	(65,394)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(454,535)	393,156	0	(61,379)	29								

STATE OF ILLINOIS

Facility Name & ID Number Westchester Health & Rehabilitation Center# 0047373

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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)	
	D. Ownership													
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	0	33,887	0	0	0	0	0	0	0	0	0	33,887	32
33	Real Estate Taxes	0	358	0	0	0	0	0	0	0	0	0	358	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	17,760	0	0	0	0	0	0	0	0	0	17,760	35
36	Other (specify):*	0	24,755	0	0	0	0	0	0	0	0	0	24,755	36
37	TOTAL Ownership	0	76,760	0	76,760	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	17,301	0	0	0	0	0	0	0	0	0	17,301	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	17,301	0	17,301	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(454,535)	487,217	0	32,682	45								

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	Montebello Healthcare Center	Hamilton			
		Nature Trail Healthcare Center	Mount Vernon			
		Odin Healthcare Center	Odin			
		Westchester Healthcare Center	Westchester			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	5 Utilities	\$	SSC Equity Holdings LLC	100.00%	\$		1	
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	16,280	16,280	2	
3	V	39 Professional Services		SSC Equity Holdings LLC	100.00%	17,301	17,301	3	
4	V	20 Fee, Subscriptions & Promos		SSC Equity Holdings LLC	100.00%	1,426	1,426	4	
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%			5	
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	298,034	298,034	6	
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	49,359	49,359	7	
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	11,094	11,094	8	
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	24,755	24,755	9	
10	V	33 Taxes - Property		SSC Equity Holdings LLC	100.00%	358	358	10	
11	V	35 Rental and Lease		SSC Equity Holdings LLC	100.00%	17,760	17,760	11	
12	V	32 Interest Income/Expense		SSC Equity Holdings LLC	100.00%	33,887	33,887	12	
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	16,963	16,963	13	
14	Total		\$			\$ 487,217	\$ *	487,217	14

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

Facility Name & ID Number Westchester Health & Rehabilitation Center # 0047373 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 & Rehabilitation Center

0047373

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

SSC Equity Holdings LLC

Street Address

5300 W Sam Houston Parkway N, Ste 100

City / State / Zip Code

Houston, TX 77041

Phone Number

(832 467 6000

Fax Number

(832 467 6983

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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			\$	\$		0	1
2	6	Repair and Maintenance						16,280	2
3	39	Professional Services						17,301	3
4	20	Fee, Subscriptions & Promos						1,426	4
5	10	Nursing & Medical Records						0	5
6	21	Clerical & Gen Office Exp						298,034	6
7	24	Travel & Seminar						49,359	7
8	26	Insurance						11,094	8
9	36	Depreciation						24,755	9
10	33	Taxes - Property						358	10
11	35	Rental and Lease						17,760	11
12	32	Interest Income/Expense						33,887	12
13	22	Payroll Taxes						16,963	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				\$	\$		487,217	25

Facility Name & ID Number

Westchester Health & Rehabilitation Center

0047373

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	285,614	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.)		\$	280,873	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(4,741)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	276,961	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	272,220	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	266,504	8	
	2005	279,350	9	
	2006	280,603	10	
	2007	285,614	11	
	2008	280,873	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

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

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
Improvement Type**										
9	12.5 Ton RTU - Kitchen - 50% downpayment		2005	6,484	648	10	648		2,862	9
10	Concrete Sidewalk 1/3 downpayment		2005	1,628	139	12	139		623	10
11	12.5 Ton RTU - Kitchen - Balance		2005	6,484	648	10	648		2,810	11
12	Concrete Sidewalk		2005	3,389	293	11.5	293		1,268	12
13	Plumbing Project		2005	4,750	401	11.8	401		1,840	13
14	Plumbing Repairs		2005	10,000	845	11.8	845		3,873	14
15	Instl Door w/Closer - Exit Device		2005	2,576	224	11.5	224		952	15
16	Mixing Valve Spout - Kitchen		2005	2,207	192	11.5	192		815	16
17	Dry Sprinkler System Repair		2005	2,159	188	11.5	188		798	17
18	Repair Dry Sprinkler System		2005	1,893	165	11.5	165		699	18
19	Heat Pump		2005	1,255	109	11.5	109		464	19
20	Double Swing Gates - Dumpster		2005	1,226	153	8	153		651	20
21	Heat - Shower Room		2005	19,832	1,983	10	1,983		8,429	21
22	Remove Carpet and Install Tile		2005	37,384	3,738	10	3,738		15,265	22
23										23
24	Emergency Generator		2006	2,907	258	11.25	258		1,034	24
25	Paint Project - Deposit		2006	4,700	940	5	940		3,760	25
26	16: 2" Wood Blinds		2006	1,647	329	5	329		1,236	26
27	Front Automatic Doors - 50% Deposit		2006	7,122	712	10	712		2,670	27
28	13: Cubicle Curtains W/Mesh		2006	2,037	407	5	407		1,494	28
29	16: Single Rod Valances		2006	1,623	325	5	325		1,191	29
30	Paint and Light Fixtures		2006	7,050	671	10.5	671		2,462	30
31	16: Wood Blinds		2006	1,718	344	5	344		1,317	31
32	15: Cubicle Curtains W/Mesh		2006	2,157	431	5	431		1,618	32
33	16: Single Rod Valances		2006	1,631	326	5	326		1,224	33
34	Painting Patient Rooms		2006	3,889	778	5	778		2,787	34
35	Painting Facility- Down Pmt		2006	4,000	800	5	800		2,867	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Westchester Health & Rehabilitation Center

0047373

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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		\$ 2,787	37
38	Painting Resident Rooms	2006	4,400	880	5	880		3,007	38
39	New Carpet - Admissions Office	2006	4,737	947	5	947		3,316	39
40	New Carpet - Admissions Office	2006	148	30	5	30		104	40
41	Repair Fire Alarm System	2006	1,778	178	10	178		667	41
42	Cove Base/Refurb	2006	2,462	492	5	492		1,764	42
43	Use Tax - Cove Base/Refurb	2006	171	34	5	34		123	43
44	Painting Resident Rooms - Balance	2006	6,700	1,340	5	1,340		4,578	44
45	Paint for Refurb	2006	637	127	5	127		425	45
46	Paint for Refurb	2006	499	100	5	100		341	46
47	Paint for Refurb	2006	360	72	5	72		246	47
48	Crash Rails	2006	550	54	10.25	54		183	48
49	Crash Rails for Walls	2006	2,961	284	10.42	284		1,019	49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269	27	10	27		85	51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21	2	10	2		7	52
53	Carpet/Labor	2007	4,440	888	5	888		2,886	53
54	Front Automatic Doors - Balance	2007	7,122	712	10	712		2,552	54
55	10: Overbed Lights	2007	1,689	169	10	169		563	55
56	Use Tax - 10: Overbed Lights	2007	131	13	10	13		44	56
57	59: Wall Boxes/Sconce Lights	2007	1,675	167	10	167		558	57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127	13	10	13		42	58
59	Remodel North & South Front Exit	2007	1,049	108	9.75	108		314	59
60	Heat/Cool Unit	2007	959	98	9.83	98		293	60
61	Connect Kit Heat/AC Unit	2007	46	5	9.83	5		14	61
62	Repair to Walk In Freezer	2007	5,177	522	9.92	522		1,610	62
63	Fire Sprinkler Repair	2007	2,826	285	9.92	285		879	63
64	Design Fee	2007	2,900	288	10.08	288		935	64
65	Design Fee	2007	225	22	10.08	22		72	65
66	50 Overbed Lights and Wall Sconces	2007	8,572	843	10.16	843		2,810	66
67	50 Overbed Lights and Wall Sconces	2007	664	65	10.16	65		218	67
68	61 Mount Wall Box Sconces	2007	1,741	176	9.92	176		541	68
69	61 Mount Wall Box Sconces	2007	135	14	9.92	14		42	69
70	TOTAL (lines 4 thru 69)		\$ 210,809	\$ 25,781		\$ 25,781	\$	\$ 98,034	70

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

Facility Name & ID Number Westchester Health & Rehabilitation Center

0047373

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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		\$ 210,809	\$ 25,781		\$ 25,781	\$	\$ 98,034	1
2	29 Oxygen Concentrators	2007	15,536	1,593	9.75	1,593		4,647	2
3	29 Oxygen Concentrators	2007	1,204	123	9.75	123		360	3
4	Cr: Void Ck Village Westchester	2007	(1,049)	(108)	9.75	(108)		(314)	4
5	Permit Fee to Remode;	2007	1,049	109	9.66	109		307	5
6	Connection Kit Heat/Cool Unit	2007	46	5	9.83	5		14	6
7	2 Connect Kits Heat/AC Units	2007	92	9	9.83	9		28	7
8	Cr on Heat/AC Unit	2007	(891)	(91)	9.75	(91)		(267)	8
9	4 Heat/Cool Units	2007	3,564	362	9.83	362		1,087	9
10	4 Power Conn Kits Heat/AC Units	2007	201	20	9.83	20		61	10
11	Furnace Repair	2007	1,380	140	9.83	140		421	11
12	Heat Repair	2007	3,033	303	10	303		1,213	12
13	Repair 8 Heat AC Units	2007	11,700	1,170	10	1,170		4,680	13
14	Boiler Repair	2007	661	68	9.75	68		198	14
15	Remodel North/Southwest Exits	2007	53,930	5,627	9.58	5,627		15,476	15
16	AC Unit	2007	4,835	483	10	483		1,612	16
17	AC Unit	2007	375	37	10	37		125	17
18	Water Heater	2007	1,866	191	9.75	191		558	18
19	Stainless Steel End Wall Kitchen	2007	1,261	134	9.41	134		346	19
20									20
21	2:AC Compressor Units	2008	9,874	1,067	9.25	1,067		2,580	21
22	Steel Door	2008	1,675	186	9	186		403	22
23	Furnace 50% Deposit	2008	2,759	315	8.75	315		604	23
24	Compressor For Cooling System	2008	3,993	428	9.33	428		1,070	24
25	Furnace -Final Payment	2008	2,759	318	8.66	318		584	25
26	Steel Door - Balance	2008	1,675	191	8.75	191		367	26
27	2: Zonline Heat/Cool Units	2008	1,341	155	8.66	155		284	27
28	Heat Exchanger for Boiler	2008	7,510	875	8.58	875		1,531	28
29	6: Zonline heat/Cool Units	2008	3,636	727	5	727		1,030	29
30	AT&T Circuit Conversion	2008	32,788	4,015	8.16	4,015		5,353	30
31	AT&T Circuit Conversion	2008	6,306	788	8	788		919	31
32	Blower Assembly	2008	3,511	439	8	439		512	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 387,429	\$ 45,463		\$ 45,463	\$	\$ 143,823	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 387,429	\$ 45,463		\$ 45,463	\$	\$ 143,823	1
2	3: Zoneline Heat/Cool Units	2009	1,999	157	7.42	157		157	2
3	Condenser fan motor	2009	8,348	742	7.5	742		742	3
4	2: Zoneline Heat/Cool Units	2009	1,333	91	7.34	91		91	4
5	Front Entry Paint	2009	6,241	624	5	624		624	5
6	Replc glass valve & thermometer	2009	2,500	60	7	60		60	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	TOTAL (lines 1 thru 33)		\$ 407,850	\$ 47,137		\$ 47,137	\$	\$ 145,497	34

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

Facility Name & ID Number Westchester Health & Rehabilitation Center

0047373

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 243,915	\$ 27,176	\$ 27,176	\$	10	\$ 93,726	71
72	Current Year Purchases	154,155	7,499	7,499		10	7,499	72
73	Fully Depreciated Assets	(8,398)						73
74								74
75	TOTALS	\$ 389,672	\$ 34,675	\$ 34,675	\$		\$ 101,225	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)	\$ 797,522	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,812	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,812	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)	\$ 246,722	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>1/1/2005</u>	\$ <u>531,541</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ <u>531,541</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES 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	TOTAL		\$ _____	\$ _____	21

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. 12/2010 \$ 531,541

13. 12/2011 \$ 531,541

14. 12/2012 \$ 531,541

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	2450 hrs	\$ 106,937		\$		2,450	\$ 106,937	1
2	Licensed Speech and Language Development Therapist	10a-3	1713 hrs	73,694				1,713	73,694	2
3	Licensed Recreational Therapist	10a-3	hrs							3
4	Licensed Physical Therapist	10a-3	5783 hrs	219,247				5,783	219,247	4
5	Physician Care	39	visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				175,112		175,112	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			\$ 399,878		\$	\$ 175,112	9,946	\$ 574,990	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 300	\$	1
2	Cash-Patient Deposits	96,872		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	568,584		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	991		6
7	Other Prepaid Expenses	152,224		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 818,971	\$	10
B. Long-Term Assets				
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	410,593		15
16	Equipment, at Historical Cost	389,672		16
17	Accumulated Depreciation (book methods)	(246,724)		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): <u>leasehold rights</u>	43,641		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 633,947	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,452,918	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 122,910	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	343,095		30
31	Accrued Taxes Payable (excluding real estate taxes)	47,825		31
32	Accrued Real Estate Taxes(Sch.IX-B)	280,873		32
33	Accrued Interest Payable			33
34	Deferred Compensation	67,437		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Miscellaneous</u>	7,266		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 869,406	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany</u>	1,356,922		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,356,922	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,226,328	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (773,410)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,452,918	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,344,194)	1
2	Restatements (describe):	35,837	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,308,357)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	534,947	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)	\$ 534,947	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (773,410)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Westchester Health & Rehabilitation Center

0047373

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,215,811	1
2	Discounts and Allowances for all Levels	(3,873,047)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,342,764	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	910,558	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 910,558	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,091	13
14	Non-Patient Meals	908	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	303,272	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,927	19
20	Radiology and X-Ray	8,815	20
21	Other Medical Services	(4,162)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 349,851	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts - Admin	8,456	28
28a	Misc Receipts - Vending	2,488	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,944	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,614,117	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,061,824	31
32	Health Care	3,406,174	32
33	General Administration	1,441,564	33
B. Capital Expense			
34	Ownership	880,242	34
C. Ancillary Expense			
35	Special Cost Centers	223,666	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,079,170	40
41	Income before Income Taxes (line 30 minus line 40)**	534,947	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 534,947	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.

Facility Name & ID Number Westchester Health & Rehabilitation Center

0047373

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	1,719	1,861	\$ 76,468	\$ 41.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,261	15,178	665,578	43.85	3
4	Licensed Practical Nurses	26,936	29,207	772,932	26.46	4
5	CNAs & Orderlies	67,132	72,361	828,948	11.46	5
6	CNA Trainees					6
7	Licensed Therapist	8,971	9,951	410,885	41.29	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,715	1,893	39,707	20.98	9
10	Activity Assistants	4,832	5,203	51,760	9.95	10
11	Social Service Workers	3,474	3,783	83,800	22.15	11
12	Dietician					12
13	Food Service Supervisor	1,869	2,085	46,709	22.40	13
14	Head Cook	5,684	6,133	90,488	14.75	14
15	Cook Helpers/Assistants	12,439	13,256	115,805	8.74	15
16	Dishwashers					16
17	Maintenance Workers	2,042	2,149	30,733	14.30	17
18	Housekeepers	13,438	14,290	185,583	12.99	18
19	Laundry	4,821	5,247	53,690	10.23	19
20	Administrator	1,871	2,087	102,477	49.10	20
21	Assistant Administrator					21
22	Other Administrative	7,692	8,364	227,266	27.17	22
23	Office Manager					23
24	Clerical	7,365	8,013	126,422	15.78	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	989	989	15,001	15.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,250	202,050	\$ 3,924,252 *	\$ 19.42	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	\$ 17,505	1-3	35
36	Medical Director	24,000	9-3	36
37	Medical Records Consultant	4,360	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,389	10-3	39
40	Physical Therapy Consultant		10a-3	40
41	Occupational Therapy Consultant		10a-3	41
42	Respiratory Therapy Consultant	480	10a-3	42
43	Speech Therapy Consultant		10a-3	43
44	Activity Consultant	8,619	11-3	44
45	Social Service Consultant	1,982	12-3	45
46	Other(specify) <u>Administrative</u>	121,281	10-3	46
47	<u>Xray and Laboratory</u>	27,271	39-3	47
48	<u>Dentist/Physician/Psychiatrist</u>	1,742	39-3	48
49	TOTAL (lines 35 - 48)	\$ 212,629		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 & Rehabilitation Center# 0047373Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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 \$5,626
- (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. \$ 40,093 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. \$ 65,700
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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman, LLC
- (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.