

Facility Name & ID Number Montebello Healthcare Center

0047340 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	139	Skilled (SNF)	139	50,735	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	139	TOTALS	139	50,735	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	18,986	5,559	3,231	27,776	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,986	5,559	3,231	27,776	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.75%

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 139 and days of care provided 2,997

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	135,242	13,824	13,076	162,142		162,142		162,142		1
2	Food Purchase		148,633		148,633		148,633	(147)	148,486		2
3	Housekeeping	92,309	11,070	2,889	106,268		106,268		106,268		3
4	Laundry	23,780	10,129		33,909		33,909		33,909		4
5	Heat and Other Utilities			91,763	91,763		91,763	(4,467)	87,296		5
6	Maintenance	36,870	71,001	12,942	120,813		120,813	15,558	136,371		6
7	Other (specify):* Waste Disposal			7,345	7,345		7,345		7,345		7
8	TOTAL General Services	288,201	254,657	128,015	670,873		670,873	10,944	681,817		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,308,949	85,860	11,031	1,405,840		1,405,840	173,325	1,579,165		10
10a	Therapy	152,562	24,073	196,894	373,529		373,529		373,529		10a
11	Activities	35,875	4,996	3,933	44,804		44,804		44,804		11
12	Social Services	34,831		2,497	37,328		37,328		37,328		12
13	CNA Training										13
14	Program Transportation	27,704	6,504	1,227	35,435		35,435		35,435		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,559,921	121,433	222,782	1,904,136		1,904,136	173,325	2,077,461		16
	C. General Administration										
17	Administrative	79,053			79,053		79,053	4,610	83,663		17
18	Directors Fees			525	525		525		525		18
19	Professional Services			4,977	4,977		4,977	13,634	18,611		19
20	Dues, Fees, Subscriptions & Promotions			27,539	27,539		27,539	(2,327)	25,212		20
21	Clerical & General Office Expenses	103,408	17,980	282,998	404,386		404,386	(255,552)	148,834		21
22	Employee Benefits & Payroll Taxes			290,224	290,224		290,224	38,707	328,931		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,685	13,685		13,685	27,201	40,886		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			159,342	159,342		159,342	(138,327)	21,015		26
27	Other (specify):*										27
28	TOTAL General Administration	182,461	17,980	779,290	979,731		979,731	(312,054)	667,677		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,030,583	394,070	1,130,087	3,554,740		3,554,740	(127,785)	3,426,955		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montebello Healthcare Center

#0047340

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			88,781	88,781		88,781	32,685	121,466			30
31	Amortization of Pre-Op. & Org.			6,341	6,341		6,341		6,341			31
32	Interest			(34,242)	(34,242)		(34,242)		(34,242)			32
33	Real Estate Taxes			65,844	65,844		65,844	(3,138)	62,706			33
34	Rent-Facility & Grounds			31,566	31,566		31,566	6,803	38,369			34
35	Rent-Equipment & Vehicles			13,483	13,483		13,483		13,483			35
36	Other (specify):* HO Depr/Franchise Tax			250	250		250	28,796	29,046			36
37	TOTAL Ownership			172,023	172,023		172,023	65,146	237,169			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,151	8,293	60,444		60,444		60,444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,509	226,509		226,509		226,509			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		52,151	234,802	286,953		286,953		286,953			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,030,583	446,221	1,536,912	4,013,716		4,013,716	(62,639)	3,951,077			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 Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,475)	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	(147)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(949)	21		18
19	Entertainment				19
20	Contributions	(76)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(136)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,436)	21		24
25	Fund Raising, Advertising and Promotional	(2,987)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(146)	20		28
29	Other-Attach Schedule	(291,636)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (354,988)		\$	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)	292,349		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 292,349		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (62,639)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Montebello Healthcare Center

ID# 0047340

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Back Office Services Fees	\$ (202,212)	21	1
2	Professional Liability Insurance	(141,642)	26	2
3	Real Estate Taxes - Accrual Adj	(3,138)	33	3
4	Remove Rent Averaging	6,803	34	4
5	Adjust Health Insurance to Actual	15,868	22	5
6	Adjust Depreciation to Actual	32,685	30	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		(291,636)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center# 0047340

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(147)	0	0	0	0	0	0	0	0	0	0	(147)	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	(4,475)	8	0	0	0	0	0	0	0	0	0	(4,467)	5
6	Maintenance	0	15,558	0	0	0	0	0	0	0	0	0	15,558	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,622)	15,566	0	10,944	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	173,325	0	0	0	0	0	0	0	0	0	173,325	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	173,325	0	173,325	16								
	C. General Administration													
17	Administrative	0	4,610	0	0	0	0	0	0	0	0	0	4,610	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(136)	13,770	0	0	0	0	0	0	0	0	0	13,634	19
20	Fees, Subscriptions & Promotions	(3,133)	806	0	0	0	0	0	0	0	0	0	(2,327)	20
21	Clerical & General Office Expenses	(257,673)	2,121	0	0	0	0	0	0	0	0	0	(255,552)	21
22	Employee Benefits & Payroll Taxes	15,868	22,839	0	0	0	0	0	0	0	0	0	38,707	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	27,201	0	0	0	0	0	0	0	0	0	27,201	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(141,642)	3,315	0	0	0	0	0	0	0	0	0	(138,327)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(386,716)	74,662	0	(312,054)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(391,338)	263,553	0	(127,785)	29								

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center# 0047340

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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	32,685	0	0	0	0	0	0	0	0	0	0	32,685	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(3,138)	0	0	0	0	0	0	0	0	0	0	(3,138)	33
34	Rent-Facility & Grounds	6,803	0	0	0	0	0	0	0	0	0	0	6,803	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* HO Depr	0	28,796	0	0	0	0	0	0	0	0	0	28,796	36
37	TOTAL Ownership	36,350	28,796	0	65,146	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(354,988)	292,349	0	(62,639)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	Montebello Health Care Center	Hamilton			
		Nature Trail Health Care Center	Mount Vernon			
		Odin Health Care Center	Odin			
		Westchester Health and Rehab 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:	
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%	\$ 8	\$ 8	1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	15,558	15,558	2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	13,770	13,770	3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	806	806	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	173,325	173,325	5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	2,121	2,121	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	27,201	27,201	7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	3,315	3,315	8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	28,796	28,796	9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	4,610	4,610	10
11	V	35 Rental and Lease		SSC Equity Holdings LLC	100.00%			11
12	V	32 Interest Income/Expense		SSC Equity Holdings LLC	100.00%			12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	22,839	22,839	13
14	Total		\$			\$ 292,349	\$ * 292,349	14

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

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 Montebello Healthcare Center

0047340 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 Pkwy N Ste 100
 City / State / Zip Code Houston, TX 77041
 Phone Number (832-467-6000
 Fax Number (832-467-6983

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			\$	\$		8	1
2	6	Repair and Maintenance						15,558	2
3	19	Professional Services						13,770	3
4	20	Fee, Subscriptions and Promos						806	4
5	10	Nursing & Medical Records						173,325	5
6	21	Clerical & Gen Office Exp						2,121	6
7	24	Travel & Seminar						27,201	7
8	26	Insurance						3,315	8
9	36	Drpreiation						28,796	9
10	17	Communications						4,610	10
11	35	Rental and Lease							11
12	32	Interest Income/Expense							12
13	22	Payroll Taxes						22,839	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				\$	\$		292,349	25

Facility Name & ID Number

Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2012 report.		\$	<u>64,647</u>	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.)		\$	<u>62,706</u>	2											
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,941)</u>	3											
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>64,647</u>	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.		\$	<u>62,706</u>	7											
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2008	<u>59,087</u>	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$ _____ 13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____ 14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____ 15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____ 13	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14	15	LESS REFUND FROM LINE 6 \$ _____ 15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____ 13														
14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14														
15	LESS REFUND FROM LINE 6 \$ _____ 15														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16														
	2009	<u>61,493</u>	9												
	2010	<u>61,693</u>	10												
	2011	<u>61,568</u>	11												
	2012	<u>62,762</u>	12												

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montebello Healthcare Center COUNTY Hancock
 FACILITY IDPH LICENSE NUMBER 0047340
 CONTACT PERSON REGARDING THIS REPORT Martha McDaniel
 TELEPHONE 832467-6317 FAX #: 832-467-6983

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-29-999-119</u>	<u>Lot B Sub (Ex 2A Se Corner &</u>	\$ <u>62,706.00</u>	\$ <u>62,706.00</u>
2. _____	<u>377 x 145 SW Corner) NE</u>	\$ _____	\$ _____
3. _____	<u>Montebello 5-8 12-29B 11-538</u>	\$ _____	\$ _____
4. _____	<u>12-29-255-011 Keokuk Street</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>62,706.00</u></u>	\$ <u><u>62,706.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 25,581 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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	139	2005	1974	\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	6 Ton 230V RTU	2005		27,558	2,756	10	2,756		22,965	9
10	Four Heat Run Duct System	2005		1,500	133	11.5	133		1,111	10
11	Repair Damaged Phone System	2005		1,576	158	10	158		1,314	11
12	Watermain Repair	2005		8,682	777	11.5	777		6,414	12
13	Retaining Wall - Partial Payment	2005		6,359	569	11.5	569		4,698	13
14	Fire Alarm Control Panel	2005		2,404	240	10	240		1,984	14
15	Construct Walkway Cover	2005		5,022	450	11.5	450		3,710	15
16	Leveled Ground around Stairway	2005		525	47	11.5	47		388	16
17	Fire Alarm System	2005		1,824	182	10	182		1,505	17
18	Install New Handrails	2005		415	37	11.5	37		306	18
19	Fire Alarm Control Panel	2005		872	87	10	87		719	19
20	Drywall Repairs - Water Break	2005		3,975	356	11.5	356		2,937	20
21	16: Toilet and Shower Floors	2005		10,166	924	11.3	924		7,470	21
22	Front Entry Concrete	2005		7,081	644	11.3	644		5,203	22
23	6: Smoke Detectors	2005		1,480	148	10	148		1,209	23
24	Relays for Emergency Lights	2005		2,776	252	11.3	252		2,040	24
25										25
26	119 Gallon Electric Water Heater	2006		4,362	436	10	436		3,453	26
27	Use Tax: Water Heater	2006		268	27	10	27		212	27
28	Install Water Heater	2006		659	66	10	66		522	28
29	Install Electrical Water Heater	2006		384	38	10	38		304	29
30	42' Sidewalk - Outside Patio	2006		1,820	168	10.175	168		1,302	30
31	Sprinkler	2006		2,296	212	10.175	212		1,643	31
32	Repair Sprinkler System	2006		6,893	648	10	648		4,899	32
33										33
34										34
35										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 Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Deposit - Vinyl Floor	2007	\$ 1,928	\$ 196	9.25	\$ 196	\$	\$ 1,325	37
38	Vinyl Flooring	2007	2,153	224	9.08	224		1,468	38
39	Replace AC Compressor - Laundry	2007	1,663	173	9.08	173		1,134	39
40	Sprinkler System Install	2007	1,744	179	9.16	179		1,194	40
41	Vinyl Flooring 2 Shower/Bathroom	2007	475	50	9	50		322	41
42									42
43									43
44	Backflow Devices - Sprinkler System	2008	21,646	2,290	9	2,290		14,631	44
45	Generator Water Pump	2008	4,412	486	8.58	486		2,927	45
46	Foundation Upgrade	2008	5,340	594	8.5	594		3,525	46
47	Sealed 3 Cracks Below Windows	2008	1,400	153	8.66	153		933	47
48	Water Abatement & Concrete Work	2008	2,670	300	8.41	300		1,754	48
49	Fire Alarm Maintenance	2008	3,191	366	8.25	366		2,074	49
50	Genset Wiring	2008	1,903	221	8.25	221		1,230	50
51	Generatro Remote Annunicator	2008	2,349	272	8.25	272		1,519	51
52	Dry System Accelerator	2008	8,020	919	8.25	919		5,213	52
53	Water Abatement & Concrete Work	2008	2,670	306	8.25	306		1,736	53
54									54
55									55
56	Wanderguard Monitor	2009	880	114	7.3	114		534	56
57	Concrete Sidewalk	2009	3,190	428	7.08	428		1,892	57
58	Anti Scald Mixing Valve	2009	1,074	141	7.25	141		647	58
59									59
60	Basement Door Locks	2010	2,263	311	6.92	311		1,320	60
61	Fire Alarm/Air Handler Connection	2010	5,363	649	7.83	649		3,387	61
62	Wanderguard System Credit	2010	(880)	(124)	6.75	(124)		(504)	62
63	Recepticles in 20 Rooms	2010	6,800	972	6.67	972		3,862	63
64	Intumescent Firestop	2010	18,880	2,733	6.58	2,733		10,620	64
65	5 Ton Central Air Conditioner	2010	4,580	690	6.34	690		2,498	65
66	Replaced Roof Membrane	2010	4,800	765	6	765		2,499	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 207,409	\$ 22,763		\$ 22,763	\$	\$ 144,048	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 207,409	\$ 22,763		\$ 22,763	\$	\$ 144,048	1
2	Fire Alarm / Air Handler	2011	348	83	10	83		205	2
3	Install 2 Roof Top Units	2011	15,694	4,770	10	4,770		7,385	3
4	20 Wood Blinds	2011	2,964	593	5	593		1,482	4
5	17 Room Signs	2011	627	125	5	125		314	5
6	Shirred Valances and Rods	2011	2,912	582	5	582		1,407	6
7	Replace Tile & Vinyl flooring, walls, plumbing, & paint in 15 resid	2011	138,295	3,002	15	3,002		3,849	7
8	Replace electrical wiring and crown molding	2011	8,467	49,032	15	49,032		62,861	8
9									9
10	2 3 Ton Min Split Systems	2012	13,456	2,691	5	2,691		6,504	10
11	Commercial Disposal	2012	1,042	215	5	215		406	11
12									12
13	Stair Rail Panels	2013	1,991	557	4	557		557	13
14	Electrical for New Range	2013	1,285	257	3.75	257		257	14
15	NW Wing RTU Evaporator Coil	2013	2,986	364	3.4	364		364	15
16	Walk InCooler Compressor	2013	1,193	145	3.4	145		145	16
17	Nortstar Phone System	2013	15,745	1,574	3.4	1,574		1,574	17
18	A/C Blower Motor	2013	959	74	3.25	74		74	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)		\$ 415,373	\$ 86,827		\$ 86,827	\$	\$ 231,432	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 174,214	\$ 29,900	\$ 29,900	\$		\$ 112,872	71
72	Current Year Purchases	22,334	4,734	4,734			4,734	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 196,548	\$ 34,634	\$ 34,634	\$		\$ 117,606	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 611,921	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 121,461	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,461	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)	\$ 349,038	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>139</u>	<u>01/01/2005</u>	\$ <u>38,369</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		139		\$ 38,369			7

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. /2014 \$ 44,436

13. /2015 \$ 44,436

14. /2016 \$ 44,436

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Resident Transportation</u>	<u>2011 Ford E 350</u>	\$ <u>#####</u>	\$ <u>13,483</u>	17
18					18
19					19
20					20
21	TOTAL		\$ #####	\$ 13,483	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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)		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-03	598	hrs	\$ 31,915		\$ 22,170	\$	598	\$ 54,085	1
2	Licensed Speech and Language Development Therapist	10a-03		hrs			8,207			8,207	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	3154	hrs	120,646		23,795		3,154	144,441	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 prescripts				52,151		52,151	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				\$ 152,561		\$ 54,172	\$ 52,151	3,752	\$ 258,884	14

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

Facility Name & ID Number **Montebello Healthcare Center**# **0047340**Report Period Beginning: **01/01/2013**Ending: **12/31/2013****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	30,396		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	523,904		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,233		6
7	Other Prepaid Expenses	1,846		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 560,929	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,908		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	415,373		15
16	Equipment, at Historical Cost	196,549		16
17	Accumulated Depreciation (book methods)	(349,038)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	105,101		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Leasehold Rights	18,495		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 454,388	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,015,317	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 73,550	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,137		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,308)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,900		32
33	Accrued Interest Payable			33
34	Deferred Compensation	7,941		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Taxes (Other)	71,751		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 464,971	\$	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	Intercompany Revolver	819,947		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 819,947	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,284,918	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (269,601)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,015,317	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (337,312)	1
2	Restatements (describe):	36,241	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (301,071)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	31,470	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)	\$ 31,470	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)	\$ (269,601)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,940,370	1
2	Discounts and Allowances for all Levels	(593,570)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,346,800	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	546,907	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 546,907	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	145,718	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,819	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 150,541	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	Rental Receipts	47	28
28a	Vending	891	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 938	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,045,186	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	670,873	31
32	Health Care	1,904,136	32
33	General Administration	979,981	33
B. Capital Expense			
34	Ownership	171,773	34
C. Ancillary Expense			
35	Special Cost Centers	60,444	35
36	Provider Participation Fee	226,509	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,013,716	40
41	Income before Income Taxes (line 30 minus line 40)**	31,470	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 31,470	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,771,238	44
45	Private Pay - Net Inpatient Revenue	927,890	45
46	Medicare - Net Inpatient Revenue	646,906	46
47	Other-(specify) <u>HMO/Insurance</u>	14	47
48	Other-(specify) <u>VA/Hospice</u>	752	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,346,800	49

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

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

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

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

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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	1,919	2,087	\$ 66,654	\$ 31.94	1
2	Assistant Director of Nursing	1,571	1,783	38,859	21.79	2
3	Registered Nurses	12,592	13,701	307,589	22.45	3
4	Licensed Practical Nurses	16,389	17,829	288,220	16.17	4
5	CNAs & Orderlies	51,015	54,740	585,633	10.70	5
6	CNA Trainees					6
7	Licensed Therapist	3,672	3,752	152,562	40.66	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,817	1,917	25,946	13.53	9
10	Activity Assistants	982	1,039	9,929	9.56	10
11	Social Service Workers	2,048	2,230	34,831	15.62	11
12	Dietician					12
13	Food Service Supervisor	1,844	2,084	29,301	14.06	13
14	Head Cook	5,232	5,657	50,383	8.91	14
15	Cook Helpers/Assistants	6,163	6,602	55,558	8.42	15
16	Dishwashers					16
17	Maintenance Workers	1,961	2,089	36,870	17.65	17
18	Housekeepers	8,637	9,375	92,309	9.85	18
19	Laundry	2,638	2,869	23,780	8.29	19
20	Administrator	1,927	2,087	79,053	37.88	20
21	Assistant Administrator					21
22	Other Administrative	3,670	3,952	103,407	26.17	22
23	Office Manager					23
24	Clerical					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	1,910	2,135	21,995	10.30	31
32	Other Health Care(specify)	1,599	1,970	27,704	14.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,586	137,898	\$ 2,030,583 *	\$ 14.73	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	\$ 11,375	1-3	35
36	Medical Director	7,200	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,868	10-3	39
40	Physical Therapy Consultant	23,795		40
41	Occupational Therapy Consultant	22,170		41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	8,207		43
44	Activity Consultant	2,711	11-3	44
45	Social Service Consultant	2,497	12-3	45
46	Other(specify) <u>Admin</u>	10,258	10-3	46
47	<u>XRay & Laboratory</u>	7,455	39-3	47
48	<u>Dentist/Physician/Psychiatrist</u>	152	39-3	48
49	TOTAL (lines 35 - 48)	\$ 101,688		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Montebello Healthcare Center# 0047340Report Period Beginning: 01/01/2013 Ending: 12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$6,033
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,957 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. \$ 226,509
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? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman, LLC (Corporate Level)
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.