

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	31,623	3,130	6,010	40,763	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,623	3,130	6,010	40,763	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.07%

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

9 (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)

NA

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 3,026

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	(796)	2,180	610,755	612,139	612,139	(252,323)	359,816			1
2	Food Purchase		(3,358)		(3,358)	(3,358)	251,915	248,557			2
3	Housekeeping		10,669	140,647	151,316	151,316		151,316			3
4	Laundry		7,087	94,287	101,374	101,374		101,374			4
5	Heat and Other Utilities			196,360	196,360	196,360	(9,821)	186,539			5
6	Maintenance	48,296	130,488	20,360	199,144	199,144	27,389	226,533			6
7	Other (specify):*			13,834	13,834	13,834		13,834			7
8	TOTAL General Services	47,500	147,066	1,076,243	1,270,809	1,270,809	17,160	1,287,969			8
	B. Health Care and Programs										
9	Medical Director			22,400	22,400	22,400		22,400			9
10	Nursing and Medical Records	2,516,000	201,170	112,773	2,829,943	2,829,943	273,881	3,103,824			10
10a	Therapy	411,210	46,046	12,934	470,190	470,190		470,190			10a
11	Activities	77,651	6,045	18,986	102,682	102,682		102,682			11
12	Social Services	93,649			93,649	93,649		93,649			12
13	CNA Training										13
14	Program Transportation		12	2,910	2,922	2,922		2,922			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,098,510	253,273	170,003	3,521,786	3,521,786	273,881	3,795,667			16
	C. General Administration										
17	Administrative	105,934			105,934	105,934	4,625	110,559			17
18	Directors Fees			591	591	591		591			18
19	Professional Services			54,302	54,302	54,302	(10,191)	44,111			19
20	Dues, Fees, Subscriptions & Promotions			33,785	33,785	33,785	949	34,734			20
21	Clerical & General Office Expenses	188,861	15,631	662,260	866,752	866,752	(687,709)	179,043			21
22	Employee Benefits & Payroll Taxes			550,887	550,887	550,887	38,768	589,655			22
23	Inservice Training & Education										23
24	Travel and Seminar			8,211	8,211	8,211	29,190	37,401			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			290,821	290,821	290,821	114,692	405,513			26
27	Other (specify):* Franchise Tax						300	300			27
28	TOTAL General Administration	294,795	15,631	1,600,857	1,911,283	1,911,283	(509,376)	1,401,907			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,440,805	415,970	2,847,103	6,703,878	6,703,878	(218,335)	6,485,543			29

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

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

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

#0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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			161,488	161,488		161,488	(434)	161,054			30
31	Amortization of Pre-Op. & Org.			4,611	4,611		4,611		4,611			31
32	Interest			(664)	(664)		(664)	30,182	29,518			32
33	Real Estate Taxes			378,772	378,772		378,772	(2,549)	376,223			33
34	Rent-Facility & Grounds			1,201,770	1,201,770		1,201,770	(110,237)	1,091,533			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							42,207	42,207			36
37	TOTAL Ownership			1,745,977	1,745,977		1,745,977	(40,831)	1,705,146			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,812	19,430	128,242		128,242		128,242			39
40	Barber and Beauty Shops			7,304	7,304		7,304		7,304			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			294,843	294,843		294,843		294,843			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		108,812	321,577	430,389		430,389		430,389			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,440,805	524,782	4,914,657	8,880,244		8,880,244	(259,166)	8,621,078			45

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	(313)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,863)	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	(95)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment		24		19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(32,862)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(222,422)	21		24
25	Fund Raising, Advertising and Promotional	(45,242)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(427,883)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (740,110)		\$	30

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)	480,944		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 480,944		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (259,166)		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

BHF USE ONLY						
48		49		50		51
						52

Westchester Hlth & Rehab Ctr

ID# 0047373

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Rent Averaging	\$ (110,237)	34	1
2	Reclass Franchise Tax to Line 27	(300)	33	2
3	Reclass Franchise Tax to Line 27	300	27	3
4	Real Estate Accrual Adjustment	(2,249)	33	4
5	Back Office Service Fee	(421,650)	21	5
6	Professional Liability Insruance Adjustment	106,687	26	6
7	Depreciation Adjustment	(434)	30	7
8	Reclass Food Expense from Outsource Services	(252,323)	1	8
9	Reclass Food Expense from Outsource Services	252,323	2	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		(427,883)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	(252,323)	0	0	0	0	0	0	0	0	0	0	(252,323)	1
2	Food Purchase	251,915	0	0	0	0	0	0	0	0	0	0	251,915	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	(9,863)	42	0	0	0	0	0	0	0	0	0	(9,821)	5
6	Maintenance	0	27,389	0	0	0	0	0	0	0	0	0	27,389	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,271)	27,431	0	17,160	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	273,881	0	0	0	0	0	0	0	0	0	273,881	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	273,881	0	273,881	16								
	C. General Administration													
17	Administrative	0	4,625	0	0	0	0	0	0	0	0	0	4,625	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(32,862)	22,671	0	0	0	0	0	0	0	0	0	(10,191)	19
20	Fees, Subscriptions & Promotions	0	949	0	0	0	0	0	0	0	0	0	949	20
21	Clerical & General Office Expenses	(690,744)	3,035	0	0	0	0	0	0	0	0	0	(687,709)	21
22	Employee Benefits & Payroll Taxes	0	38,768	0	0	0	0	0	0	0	0	0	38,768	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	29,190	0	0	0	0	0	0	0	0	0	29,190	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	106,687	8,005	0	0	0	0	0	0	0	0	0	114,692	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	TOTAL General Administration	(616,619)	107,243	0	(509,376)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(626,890)	408,555	0	(218,335)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015 Ending:

12/31/2015

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	(434)	0	0	0	0	0	0	0	0	0	0	(434)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	30,182	0	0	0	0	0	0	0	0	0	30,182	32
33	Real Estate Taxes	(2,549)	0	0	0	0	0	0	0	0	0	0	(2,549)	33
34	Rent-Facility & Grounds	(110,237)	0	0	0	0	0	0	0	0	0	0	(110,237)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	42,207	0	0	0	0	0	0	0	0	0	42,207	36
37	TOTAL Ownership	(113,220)	72,389	0	(40,831)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(740,110)	480,944	0	0	0	0	0	0	0	0	0	(259,166)	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	SSC Equity Holdings LLC		Holding Company
		Nature Trail Health Care Center	Mount Vernon	SSC Administrative Services LLC		Back Office Service
		Odin Health Care Center	Odin	SSC Consulting Services		Operations and Con
		Westchester Health Care Center	Westchester			
		Brentwood Sub Acute Health Care Center	Burbank			

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%	\$ 42	\$ 42	1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	27,389	27,389	2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	22,671	22,671	3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	949	949	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	273,881	273,881	5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	3,035	3,035	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	29,190	29,190	7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	8,005	8,005	8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	42,207	42,207	9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	4,625	4,625	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%	30,182	30,182	12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	38,768	38,768	13
14	Total		\$			\$ 480,944	\$ * 480,944	14

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

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC	100	Cedar Crest	Montgomery				1
2			Fairview Health & Rehab Center	Birmingham				2
3			Montrose Bay Healthcare Center	Fairhope				3
4			South Haven Health & Rehab Center	Montgomery				4
5			Warren Manor	Selma				5
6			Woodley Manor	Montgomery				6
7			Excell Health Care Center	Oakland				7
8			Flagship Health care Center	Newport Beach				8
9			Tarzana Health & Rehab Center	Tarzana				9
10			Diamond Ridge Health Care Center	Pittsburgh				10
11			Courtyard Care Center	San Jose				11
12			Mission Carmichael Health Care Center	Carmichael				12
13			AlpineLiving Center	Thornton				13
14			Boulder Manor	Boulder				14
15			Pearl Street Health Care Center	Englewood				15
16			Applewood Living Center	Longmont				16
17			Fort Collins Health Care Center	Fort Collins				17
18			Spring Creek Healthcare Center	Fort Collins				18
19			Berthoud Living Center	Berthoud				19
20			Sierra Vista Health Care Center	Loveland				20
21			Windsor Health Care Center	Windsor				21
22			San Juan Living Center	Montrose				22
23			Four Corners Health Care Center	Durango				23
24			Palisade Living Center	Palisade				24
25			Colonial Columns Nursing Center	Colorado Springs				25
26			Cedarwood Health Care Center	Colorado Springs				26
27			Minnequa Medicenter	Pueblo				27
28			Terrace Gaedens Healthcare Center	Colorado Springs				28
29			Aspen Living Cente	Colorado Springs				29
30			Belmont Lodge	Pueblo				30

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Centennial Healthcare Center	Greeley				1
2			Kenton Manor	Greeley				2
3			Stering Living Center	Sterling				3
4			Sunset Manor	Brush				4
5			Yuma Life Care Center	Yuma				5
6			Jewell Care Center of Denver	Denver				6
7			Monaco Parkway	Denver				7
8			Garden Square at Spring Creek	Fort Collins				8
9			Pendleton Health & Rehab	Mystic				9
10			Bride Brook Health & Rehab	Niantic				10
11			Brian Center Nursing Care Austell	Austll				11
12			Brian Center Health & Rehab Canton	Canton				12
13			Northeast Atlanta Healty & Rehab	Atlanta				13
14			Brighton Place West	Topeka				14
15			Indian Creek Healht Care Center	Overland Park				15
16			SE Massachusetts Health & Rehab	New Bedford				16
17			Methuen Health & Rehab Center	Methuen				17
18			Patuxent River Health & Rehab Center	Laurel				18
19			Arcola Heatlh & Rehab Center	Silver Spring				19
20			Glen Burnie Health & Rehab Center	Glen Burnie				20
21			Overlea Health & Rehab Center	Baltimore				21
22			Bethesda Health & Rehab Center	Bethesda				22
23			Summit Park Health & Rehab Center	Catonsville				23
24			North Arundel Health & Rehab Center	Glen Burnie				24
25			Bel Air Health & Rehab Center	Bel Air				25
26			Forest Hill Health & Rehab Center	Forest Hill				26
27			Heritage Harbour Health & Rehab Center	Annapolis				27
28			Cambridge East	Madison Heights				28
29			Cambridge North	Clawson				29
30			Cambridge South	Beverly Hills				30

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Clarkston	Clarkston				1
2			Clinton-Aire Healthcare Center	Clinton Township				2
3			Crestmont NursingCare Center	Fenton				3
4			Heritage Manor	Flint				4
5			Hope Health Care Center	Westland				5
6			Warren Woods Health Care Center	Warren				6
7			Superior Woods Health Care Center	Ypsilanti				7
8			Countrybrook Living Center	Brook Haven				8
9			Brian Center Health & Rehab Eden	Eden				9
10			Brian Center Nursing Care Lexington	Lexington				10
11			Brian Center Health & Rehab Hickory East	Hickory				11
12			Brian Center Health & Rehab Wilson	Wilson				12
13			Randolph Health & Rehab Center	Asheboro				13
14			Brian Center Health & Rehab Winston Salem	Winston Salem				14
15			Brian Center Health & RehabCharlotte	Charlotte				15
16			Brian Center Health & Rehab Windsor	Windsor				16
17			Maple Leaf Health Care	Statesville				17
18			Brian Center Health & Rehab Weaverville	Weaverville				18
19			Brian Center Health & Rehab Lincolnton	Lincolnton				19
20			Brian Center Health & Rehab Wallace	Wallace				20
21			Brian Center Health & Rehab Monroe	Monroe				21
22			Brian Center Health & RehabDurham	Durham				22
23			Brian Center Health & Rehab Goldsboro	Goldsboro				23
24			Brian Center Health & Rehab Cabarrus	Concord				24
25			Brian Center Nursing Care Shamrock	Charlotte				25
26			Brian Center Nursing Care Hickory	Hickory				26
27			Brian Center Health & Rehab Center Waynesvil	Waynesville				27
28			Brian Center Health & Rehab Clayton	Clayton				28
29			Brian Center Health & Rehab Brevard	Bervard				29
30			Brian Center Health & Rehab Yanceyville	Yanceyville				30

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Brian Center Health & Rehab Hertfort	Hertford				1
2			Brian Center Health & Rehab Spruce Pine	Spruce Pine				2
3			Brian Center Health & Rehab Hendersonville	Hendersonville				3
4			Brian Center Health & Rehab Salisbury	Salisbury				4
5			Mariner Health Care of Wilmington	Wilmington				5
6			Silver Stream Health & Rehab	Wilmington				6
7			Kenansville Health & Rehab	Kenansville				7
8			Charlotte Apts	Charlotte				8
9			Forest City Health & Rehab	Forest City				9
10			Arbor Manor Living Center	Fremont				10
11			Crete Manor	Crete				11
12			Haven Home	Kenesaw				12
13			Pawnee Manor	Pawnee City				13
14			Pierce Manor	Pierce				14
15			West Point Living Center	West Point				15
16			North Hills Health & Rehab	Wexford				16
17			West Hills Health & Rehab	Coraopolis				17
18			Broomall Health & Rehab	Broomall				18
19			Seneca Health & Rehab	Senaca				19
20			Sumter East Health & Rehab	Sumter				20
21			Golden Age Inman	Inman				21
22			Inman Healthcare	Inman				22
23			Lebanon Health & REhab	Lebanon				23
24			Greenhills Health & Rehab	Nashville				24
25			Norris Health & Rehab	Andersonville				25
26			Newport Health & Rehab	Newport				26
27			Cheyenne Healthcare	Cheyenne				27
28			Poplar Living Center	Casper				28
29			Sheridan Manor	Sheridan				29
30			Huntington Health Care	Huntington				30

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Bastrop Nursing Center	Bastrop				1
2			Care Inn of La Grange	La Grange				2
3			Kountze Nursing Center	Kountze				3
4			Retama Manor Nursing Center San Antonio Nor	San Antonio				4
5			Retama Manor Nursing Center San Antonio We	San Antonio				5
6			Retama Manor Nursing Center Alice	Alice				6
7			Retama Manor Nursing Center Edinburg	Edinburg				7
8			Retama Manor Nursing Center Harlingen	Harlingen				8
9			Retama Manor Nursing Center Jourdanton	Jourdanton				9
10			Retama Manor Nursing Center Laredo South	Laredo				10
11			Retama Manor Nursing Center Laredo West	Laredo				11
12			Retama Manor Nursing Center McAllen	McAllen				12
13			Retama Manor Nursing Center Pleasanton Nortl	Pleasanton				13
14			Retama Manor Nursing Center Pleasanton Soutl	Pleasanton				14
15			Retama Manor Nursing Center Rio Grande City	Rio Grande City				15
16			Retama Manor Nursing Center Robstown	Robstown				16
17			Retama Manor Nursing Center Weslaco	Weslaco				17
18			Weatherford health Care Center	Weatherford				18
19			Peach Tree Place	Weatherford				19
20			Retama Manor Nursing Center Raymondville	Raymondville				20
21			Memorial City Health and Rehab	Houston				21
22			Jacinto City Healthcare Center	Houston				22
23			Spring Branch Healthcare Center	Houston				23
24			Retama Manor Nursing Center Corpus Christi N	Corpus Christi				24
25			Downtown Health & Rehab	Fort Worth				25
26			Lakeshore Village Healthcare Center	Waco				26
27			Deer Creek of Wimberley	Wimberley				27
28			La Paloma Nursing Center	San Diego				28
29			Pine Arbor	Silsbee				29
30			Las Palmas Healthcare Center	McAllen				30

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Hilltop Village	Kerville				1
2			Silver Creek Manor	San Antonio				2
3			Alpine Terrace	Kerrville				3
4			Edgewater Care Center	Kerrville				4
5			Arlington Heights Health & Rehab	Fort Worth				5
6			The Meadows Health & Rehab	Dallas				6
7			Northgate Health & Rehab	San Antonio				7
8			Interlochen Health & Rehab	Arlington				8
9			First Colony Health & Rehab	Missouri City				9
10			Cypresswood Health & Rehab	Houston				10
11			Northwest Health & Rehab	Houston				11
12			The Westbury Place	Houston				12
13			Westchase Health & Rehab	Houston				13
14			Woodwind Lakes Health & Rehab	Houston				14
15			Pasadena Care Center	Pasadena				15
16			Bay Villa	Bay City				16
17			Alice Health care Center	Alice				17
18			Bangs Nursing Home	Bangs				18
19			Brazosview	Richmond				19
20			Courtyards at Fort Worth	Fort Worth				20
21			Faith Memorial	Pasadena				21
22			Golden Years	Marlin				22
23			Greenview Manor	Waco				23
24			Hillview Health & Rehab	Goldthwaite				24
25			Levelland Health Care	Levelland				25
26			Longmeadow Health Care	Justin				26
27			Memorial Medical Nursing Center	San Antonio				27
28			Mount Pleasant	Mount Pleasant				28
29			North Park Health & Rehab	McKinney				29
30			Pampa Health Care Center	Pampa				30

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Park Highlands Health Care Center	Athens				1
2			Pleasant Springs Health Care Center	Mount Pleasant				2
3			Sweeny Health Care Center	Sweeny				3
4			Texoma Health Care Center	Sherman				4
5			The Park in Plano	Plano				5
6			Ashland Health & Rehab	Ashland				6
7			Southpointe Health Care Center	Greenfield				7
8			Virginia Highlands Health & Rehab Center	Germantown				8
9			Grande Prairie Health & Rehab Center	Pleasant Prairie				9
10			Pleasant Valley Health Care Center	Derry				10
11			The Village at Alameda	Albuquerque				11
12			Hobbs Healthcare Center	Hobbs				12
13			Lake Mead Health Care Center	Henderson				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

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 Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending: 2/31/2015

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

(832-467-6982

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			\$ 42	\$		\$	1
2	6	Repair and Maintenance			27,389				2
3	19	Professional Services			22,671				3
4	20	Fee, Subscriptions and Promos			949				4
5	10	Nursing & Medical Records			273,881				5
6	21	Clerical & Gen Office Exp			3,035				6
7	24	Travel & Seminar			29,190				7
8	26	Insurance			8,005				8
9	36	Drpreiation			42,207				9
10	17	Communications			4,625				10
11	35	Rental and Lease							11
12	32	Interest Income/Expense			30,182				12
13	22	Payroll Taxes			38,768				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				\$ 480,944	\$		\$	25

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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.)

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westchester Hlth & Rehab Ctr COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0047373
 CONTACT PERSON REGARDING THIS REPORT Martha McDaniel
 TELEPHONE (832) 467-6317 FAX #: (832) 467-6982

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>15-29-300-018-0000</u>	<u>2901 S Wolf Rd</u>	\$ <u>343,195.00</u>	\$ <u>343,195.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>343,195.00</u></u>	\$ <u><u>343,195.00</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,531 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015 Ending:

12/31/2015

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	2005	1975	\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	12.5 Ton RTU - Kitchen - 50% downpayment	2005		6,484	378	10	378		6,484	9
10	Concrete Sidewalk 1/3 downpayment	2005		1,628	143	12	143		1,498	10
11	12.5 Ton RTU - Kitchen - Balance	2005		6,484	432	10	432		6,484	11
12	Concrete Sidewalk	2005		3,389		11.5			1,999	12
13	Plumbing Project	2005		4,750	413	11.8	413		4,371	13
14	Plumbing Repairs	2005		10,000	870	11.8	870		9,203	14
15	Instl Door w/Closer - Exit Device	2005		2,576	231	11.5	231		2,364	15
16	Mixing Valve Spout - Kitchen	2005		2,207	198	11.5	198		2,025	16
17	Dry Sprinkler System Repair	2005		2,159	193	11.5	193		1,982	17
18	Repair Dry Sprinkler System	2005		1,893	170	11.5	170		1,738	18
19	Heat Pump	2005		1,255	112	11.5	112		1,152	19
20	Double Swing Gates - Dumpster	2005		1,226		8			1,226	20
21	Heat - Shower Room	2005		19,832	1,487	10	1,487		19,832	21
22	Remove Carpet and Install Tile	2005		37,384	3,427	10	3,427		37,384	22
23										23
24	Emergency Generator	2006		2,907		11.25			1,680	24
25	Paint Project - Deposit	2006		4,700		5			4,700	25
26	16: 2" Wood Blinds	2006		1,647		5			1,647	26
27	Front Automatic Doors - 50% Deposit	2006		7,122	712	10	712		6,944	27
28	13: Cubicle Curtains W/Mesh	2006		2,037		5			2,037	28
29	16: Single Rod Valances	2006		1,623		5			1,623	29
30	Paint and Light Fixtures	2006		7,050	666	10.5	666		6,439	30
31	16: Wood Blinds	2006		1,718		5			1,718	31
32	15: Cubicle Curtains W/Mesh	2006		2,157		5			2,157	32
33	16: Single Rod Valances	2006		1,631		5			1,631	33
34	Painting Patient Rooms	2006		3,889		5			3,889	34
35	Painting Facility- Down Pmt	2006		4,000		5			4,000	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Paint and Light Fixture	2006	\$ 3,889	\$	5	\$	\$	\$ 3,889	37
38	Painting Resident Rooms	2006	4,400		5			4,400	38
39	New Carpet - Admissions Office	2006	4,737		5			4,737	39
40	New Carpet - Admissions Office	2006	148		5			148	40
41	Repair Fire Alarm System	2006	1,778	178	10	178		1,734	41
42	Cove Base/Refurb	2006	2,462		5			2,462	42
43	Use Tax - Cove Base/Refurb	2006	171		5			171	43
44	Painting Resident Rooms - Balance	2006	6,700		5			6,700	44
45	Paint for Refurb	2006	637		5			637	45
46	Paint for Refurb	2006	499		5			499	46
47	Paint for Refurb	2006	360		5			360	47
48	Crash Rails	2006	550	53	10.25	53		502	48
49	Crash Rails for Walls	2006	2,961	282	10.42	282		2,703	49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269	27	10	27		247	51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21	2	10	2		19	52
53	Carpet/Labor	2007	4,440		5			4,440	53
54	Front Automatic Doors - Balance	2007	7,122	712	10	712		6,826	54
55	10: Overbed Lights	2007	1,689	169	10	169		1,576	55
56	Use Tax - 10: Overbed Lights	2007	131	13	10	13		122	56
57	59: Wall Boxes/Sconce Lights	2007	1,675	168	10	168		1,563	57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127	13	10	13		118	58
59	Remodel North & South Front Exit	2007	1,049	107	9.75	107		951	59
60	Heat/Cool Unit	2007	959	97	9.83	97		870	60
61	Connect Kit Heat/AC Unit	2007	46	5	9.83	5		42	61
62	Repair to Walk In Freezer	2007	5,177	518	9.92	518		4,702	62
63	Fire Sprinkler Repair	2007	2,826	283	9.92	283		2,567	63
64	Design Fee	2007	2,900	285	10.08	285		2,639	64
65	Design Fee	2007	225	22	10.08	22		204	65
66	50 Overbed Lights and Wall Sconces	2007	8,572	836	10.16	836		7,805	66
67	50 Overbed Lights and Wall Sconces	2007	664	65	10.16	65		605	67
68	61 Mount Wall Box Sconces	2007	1,741	174	9.92	174		1,582	68
69	61 Mount Wall Box Sconces	2007	135	14	9.92	14		123	69
70	TOTAL (lines 4 thru 69)		\$ 210,809	\$ 13,455		\$ 13,455	\$	\$ 202,150	70

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 210,809	\$ 13,455		\$ 13,455	\$	\$ 202,150	1
2	29 Oxygen Concentrators	2007	15,536	1,580	9.75	1,580		14,087	2
3	29 Oxygen Concentrators	2007	1,204	123	9.75	123		1,092	3
4	Cr: Void Ck Village Westchester	2007	(1,049)	(107)	9.75	(107)		(951)	4
5	Permit Fee to Remode;	2007	1,049	107	9.66	107		950	5
6	Connection Kit Heat/Cool Unit	2007	46	5	9.83	5		42	6
7	2 Connect Kits Heat/AC Units	2007	92	9	9.83	9		83	7
8	Cr on Heat/AC Unit	2007	(891)	(91)	9.75	(91)		(808)	8
9	4 Heat/Cool Units	2007	3,564	359	9.83	359		3,234	9
10	4 Power Conn Kits Heat/AC Units	2007	201	20	9.83	20		182	10
11	Furnace Repair	2007	1,380	139	9.83	139		1,253	11
12	Heat Repair	2007	3,033	303	10	303		3,033	12
13	Repair 8 Heat AC Units	2007	11,700	1,170	10	1,170		11,700	13
14	Boiler Repair	2007	661	67	9.75	67		599	14
15	Remodel North/Southwest Exits	2007	53,930	5,579	9.58	5,579		48,816	15
16	AC Unit	2007	4,835	483	10	483		4,512	16
17	AC Unit	2007	375	37	10	37		350	17
18	Water Heater	2007	1,866	190	9.75	190		1,692	18
19	Stainless Steel End Wall Kitchen	2007	1,261	133	9.41	133		1,140	19
20									20
21	2:AC Compressor Units	2008	9,874	1,059	9.25	1,059		8,905	21
22	Steel Door	2008	1,675	184	9	184		1,506	22
23	Furnace 50% Deposit	2008	2,759	312	8.75	312		2,472	23
24	Compressor For Cooling System	2008	3,993	424	9.33	424		3,604	24
25	Furnace -Final Payment	2008	2,759	315	8.66	315		2,470	25
26	Steel Door - Balance	2008	1,675	190	8.75	190		1,501	26
27	2: Zoneline Heat/Cool Units	2008	1,341	153	8.66	153		1,201	27
28	Heat Exchanger for Boiler	2008	7,510	867	8.58	867		6,716	28
29	6: Zoneline heat/Cool Units	2008	3,636		5			3,636	29
30	AT&T Circuit Conversion	2008	32,788	3,974	8.16	3,974		29,145	30
31	AT&T Circuit Conversion	2008	6,306	780	8	780		5,591	31
32	Blower Assembly	2008	3,511	434	8	434		3,113	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 387,429	\$ 32,253		\$ 32,253	\$	\$ 363,016	34

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 387,429	\$ 32,253		\$ 32,253	\$	\$ 363,016	1
2	3: Zonline Heat/Cool Units	2009	1,999	267	7.42	267		1,754	2
3	Condenser fan motor	2009	8,348	1,101	7.5	1,101		7,339	3
4	2: Zonline Heat/Cool Units	2009	1,333	180	7.34	180		1,168	4
5	Front Entry Paint	2009	6,241		5			6,241	5
6	Replace Gaas Valve & Thermometer	2009	2,500	353	7	353		2,176	6
7									7
8	2: Zonline Heat/Cool Units	2010	1,346	190	7	190		1,172	8
9	Wanderguard	2010	2,744	383	7	383		2,393	9
10	Attic Sprikler System	2010	33,760	5,064	6.66	5,064		29,118	10
11	Replaced Heat Exchanger	2010	8,224	1,175	6.92	1,175		7,147	11
12	Rplc Furnace Thermostate & Sensor	2010	2,512	359	6.92	359		2,183	12
13	Zonline Heat/Cool Unit	2010	568	9	5	9		568	13
14	3: Zonline Heat/Cool Units	2010	1,968	288	6.75	288		1,704	14
15	Attic Sprikler System	2010	52,686	7,903	0.92	7,903		45,441	15
16	Attic Sprikler System	2010	47,056	7,058	6.92	7,058		40,586	16
17	Rplc Bearing Assembly & Blower Motor	2010	6,357	919	6.83	919		5,514	17
18	Attic Sprikler System	2010	8,025	1,219	6.92	1,219		7,009	18
19	Site Survey	2010	225	36	6.16	36		192	19
20	Compressor Unit	2010	3,102	490	6.16	490		2,653	20
21	Rplc Water Heater	2010	10,077	1,591	6.25	1,591		8,618	21
22	Replace Tempering Valves	2010	4,740	769	6.08	769		4,035	22
23									23
24	Maglock	2011	798	124	6.34	124		684	24
25	3: Zonline Heat/Cool Units	2011	2,202	440	6	440		2,202	25
26	Facility Building Sign	2011	2,203	389	6.5	389		1,814	26
27									27
28	Dry Pendant Sprinkler Heads	2012	5,598	1,101	5	1,101		4,497	28
29	3: Zonline Heat/Cool Units	2012	2,343	485	5	485		1,858	29
30	Garbage Disposal	2012	756	168	5	168		588	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 605,140	\$ 64,314		\$ 64,314	\$	\$ 551,670	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 605,140	\$ 64,314		\$ 64,314	\$	\$ 551,670	1
2	Mixing Valves	2013	5,790	1,478	44	1,478		4,312	2
3	Heat Draft Inducer Motor	2013	4,043	1,032	4	1,032		3,011	3
4	Aluminum Light Pole	2013	3,200	784	4	784		2,416	4
5	Inducer	2013	3,571	912	3.75	912		2,660	5
6	5: Duct Detectors	2013	3,035	809	3.75	809		2,226	6
7	Inducer - Credit Memo	2013	(689)	(180)	3.83	(180)		(510)	7
8	A/C Motor Kitchen Area	2013	1,642	438	3.75	438		1,204	8
9	Relays for Duct Smoke Detector	2013	1,000	273	3.67	273		727	9
10	19: Damper Actuators	2013	4,370	1,220	3.58	1,220		3,150	10
11	12: Damper Actuators	2013	1,338	373	3.58	373		965	11
12	Generator Transfer Switch	2013	4,722	1,318	3.58	1,318		3,404	12
13	12 Damper Actuators	2013	1,338	373	3.58	373		965	13
14	A/C Compressor Unit #1	2013	3,668	1,048	3.5	1,048		2,620	14
15	A/C Compressor & Condenser Fan	2013	3,580	1,048	3.42	1,048		2,532	15
16	Hot Water Booster Heater - Dishwasher	2013	2,529	740	3.42	740		1,789	16
17	7: Exhaust Vents	2013	1,332	410	3.25	410		922	17
18	Motor for Unit #8	2013	2,268	698	3.25	698		1,570	18
19	Bearing Assembly Water Heater	2013	2,960	911	3.25	911		2,049	19
20	Gas Valve and Ignition Control	2013	2,294	724	3.17	724		1,570	20
21									21
22	PTAC Unit	2014	847	282	3	282		564	22
23	PTAC Unit	2014	847	282	3	282		564	23
24	A/C Heating Units 9A & 9B	2014	14,770	5,213	3	5,213		9,557	24
25	3: Exhaust Fan Motors	2014	3,235	332	9.75	332		581	25
26	Condesning Unit for # 3 A/C	2014	3,157	265	12	265		397	26
27	A/C Condenser Fan Motors	2014	1,766	148	12	148		222	27
28	Mixing Valve Cartridge	2014	2,535	254	10	254		380	28
29	Split A/C System- Laundry & Hall	2014	14,370	1,437	10	1,437		2,036	29
30	Condesner for Walkin Freezer	2014	7,790	658	11.83	658		933	30
31	Door Closer & Hing System	2014	3,074	262	11.83	262		349	31
32	10: LCN 4040 24v Door Holder	2014	7,329	733	10	733		1,099	32
33	11: Aluminum 24 LCN Closer Door	2014	7,376	637	11.58	637		743	33
34	TOTAL (lines 1 thru 33)		\$ 724,227	\$ 89,226		\$ 89,226	\$	\$ 606,677	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 724,227	\$ 89,226		\$ 89,226	\$	\$ 606,677	1
2	Fan Guard on Walk In Cooler	2015	1,956	130	10	130		130	2
3	Installed LP Switch on A/C Units	2015	2,227	148	10	148		148	3
4	Replaced Water Level Probe n Ice Machine	2015	2,447	163	10	163		163	4
5	Unit Pump on Boiler/Furnace #1	2015	3,185	265	10	265		265	5
6	Unit Pump on Boiler/Furnace #2	2015	2,650	221	10	221		221	6
7	R22 Condensor Replacement on A/C	2015	2,325	123	11	123		123	7
8	Water Heater Part - Heat	2015	643	113	10	113		113	8
9	Compressor for A/C Unit	2015	2,325	123	11	123		123	9
10	Install 15 door closers and magnets	2015	4,906	695	10	695		695	10
11	CMBS Asphalt Pavement	2015	25,125	3,926	8	3,926		3,926	11
12	Install Parking Lot Tactile & Sign	2015	2,000	214	11.67	214		214	12
13	Wood Window and Doors	2015	5,958	638	11.67	638		638	13
14	Shower Room Renovation - ADA Bariatric Shower Rebuilds	2015	55,600	3,246	11.33	3,246		3,246	14
15	Install New Control Board Blower on Furnace	2015	2,947	258	11.41	258		258	15
16	Install Gas Valve on Furnace	2015	1,488	149	10	149		149	16
17	Replaced Air Curtain on Freezer	2015	895	72	11.33	72		72	17
18	Walk in Freezer Aluminum Plate	2015	1,795	121	11.16	121		121	18
19	Norstar Phone System Install	2015	6,179	103	10	103		103	19
20	PTAC Resistance Heater	2015	767	13	5	13		13	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)		\$ 849,645	\$ 99,947		\$ 99,947	\$	\$ 617,398	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	\$ 454,715	\$ 57,809	\$ 57,809	\$		\$ 387,001	71
72	Current Year Purchases	24,935	3,298	3,298			3,298	72
73	Fully Depreciated Assets	(7,955)						73
74								74
75	TOTALS	\$ 471,695	\$ 61,107	\$ 61,107	\$		\$ 390,299	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,321,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 161,054	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 161,054	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)	\$ 1,007,697	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>1988</u>	<u>120</u>	<u>10/11/2013</u>	\$ <u>1,091,533</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 1,091,533			7

10. Effective dates of current rental agreement:

Beginning 06/02/2014

Ending 05/31/2026

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. /2016 \$ 1,199,522

13. /2017 \$ 1,199,522

14. /2018 \$ 1,199,522

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

* 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	3491	hrs	\$ 151,651		\$	\$	3,491	\$ 151,651	1
2	Licensed Speech and Language Development Therapist	10a-03	1107	hrs	51,778				1,107	51,778	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	5238	hrs	207,781				5,238	207,781	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				108,812		108,812	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				\$ 411,210		\$	\$ 108,812	9,836	\$ 520,022	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 Westchester Hlth & Rehab Ctr# 0047373Report Period Beginning: 01/01/2015Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	25,337		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,324,937		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,978		6
7	Other Prepaid Expenses	30,883		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,386,435	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	274,379		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	851,132		15
16	Equipment, at Historical Cost	473,414		16
17	Accumulated Depreciation (book methods)	(1,008,065)		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):	35,990		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 626,850	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,013,285	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 314,071	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	672,375		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	377,526		32
33	Accrued Interest Payable			33
34	Deferred Compensation	34,531		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	191,344		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,589,847	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>CLO & Intercompany</u>	1,923,991		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,923,991	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,513,838	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,013,285)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,500,553	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,365,132)	1
2	Restatements (describe):	(185,541)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,550,673)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(462,612)	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)	\$ (462,612)	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)	\$ (2,013,285)	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	\$ 8,307,022	1
2	Discounts and Allowances for all Levels	(1,052,880)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,254,142	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	942,462	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 942,462	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	9,482	13
14	Non-Patient Meals	625	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	169,081	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,200	19
20	Radiology and X-Ray	10,695	20
21	Other Medical Services	3,244	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 218,327	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Receipts</u>	2,701	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,701	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,417,632	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,270,809	31
32	Health Care	3,521,786	32
33	General Administration	1,911,283	33
B. Capital Expense			
34	Ownership	1,745,977	34
C. Ancillary Expense			
35	Special Cost Centers	135,546	35
36	Provider Participation Fee	294,843	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,880,244	40
41	Income before Income Taxes (line 30 minus line 40)**	(462,612)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (462,612)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,308,016	44
45	Private Pay - Net Inpatient Revenue	897,556	45
46	Medicare - Net Inpatient Revenue	736,036	46
47	Other-(specify) <u>HMO/Insurance</u>	26,601	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	285,933	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,254,142	49

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

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

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

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	2,080	2,328	\$ 105,710	\$ 45.41	1
2	Assistant Director of Nursing	1,552	1,779	64,068	36.01	2
3	Registered Nurses	7,650	8,318	249,247	29.96	3
4	Licensed Practical Nurses	36,069	39,342	1,024,549	26.04	4
5	CNAs & Orderlies	69,869	75,516	1,042,274	13.80	5
6	CNA Trainees					6
7	Licensed Therapist	8,869	9,836	411,210	41.81	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,090	2,281	52,108	22.84	9
10	Activity Assistants	1,983	2,196	25,543	11.63	10
11	Social Service Workers	3,830	4,185	93,649	22.38	11
12	Dietician					12
13	Food Service Supervisor		56		0.00	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,944	2,120	48,296	22.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,032	2,360	105,934	44.89	20
21	Assistant Administrator					21
22	Other Administrative	3,111	3,993	116,220	29.11	22
23	Office Manager					23
24	Clerical	4,506	5,034	71,845	14.27	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	1,926	1,931	30,152	15.61	31
32	Other Health C: <u>Medicare Coord</u>		45		0.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,511	161,320	\$ 3,440,805 *	\$ 21.33	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	\$ 610,405	1-3	35
36	Medical Director	22,400	9-3	36
37	Medical Records Consultant	4,784	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	9,889	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	191	10a-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	17,205	11-3	44
45	Social Service Consultant		12-3	45
46	Other(specify) <u>Admin</u>	138,830	10-3	46
47	<u>Xray & Laboratory</u>	18,625	39-3	47
48	<u>Dentis/Physician/Psychiatrist</u>	388	39-3	48
49	TOTAL (lines 35 - 48)	\$ 822,717		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Martin Lee	Administrator	0	\$ 55,857	Workers' Compensation Insurance	\$ 69,885	IDPH License Fee	\$	
Kevin Meals	Administrator	0	50,077	Unemployment Compensation Insurance	95,202	Advertising: Employee Recruitment	9,405	
				FICA Taxes	258,430	Health Care Worker Background Check	4,608	
				Employee Health Insurance	120,584	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	880	
				Life Insurance	2,809	Professional Dues	12,178	
				Other Benefits	3,977	Other Licenses	3,216	
				Home Office Payroll Taxes	38,768			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 105,934	TOTAL (agree to Schedule V, line 22, col.8)		\$ 34,734		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising 4,447	
			\$				Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 37,401	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sevarus Corp/Bryan Cave LLP	Survey Tracking/Legal Svc		\$ 115			\$	Out-of-State Travel	\$ 2,675
Ogletree Deakins Nash	Legal Svcs		4,073					
Bradley Associates/Probate Finders	Physician consultant		730				In-State Travel	2,403
Burgeon Legal Group	Legal Svcs		28,208					
Equifax	Background		655				Seminar Expense	3,133
Cass Info/LexisNexi	Expense Mgmt/Risk Data		1,550				Home Office Allocation	29,190
TALX	Unemployment Comp Srvc		315				Entertainment Expense ()	
Illinois State Police	Background		870				(agree to Sch. V, line 24, col. 8)	
Compsych	Employee Services		1,209				TOTAL	\$ 37,401
Duane Morris LLP	Legal Svcs		559					
Worsek & Vihon	Legal Svcs - RE Tax		14,847					
National Research	Quality Care Analysis		1,171					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 54,302	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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 Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. IllinoisHealth Care Association \$10,883
- (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. \$ 56,024 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. \$ 294,843
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.