

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0047373</u></p> <p>Facility Name: <u>Westchester Hlth & Rehab Ctr</u></p> <p>Address: <u>2901 South Wolf Road</u> <u>Westchester</u> <u>60154</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>708 531 1441</u> Fax # <u>708 409 1271</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/06/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Martha McDaniel</u> Telephone Number: <u>832-467-6317</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>Senior Vice President of Planning and Reimbursement</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>Senior Vice President of Planning and Reimbursement</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>Senior Vice President of Planning and Reimbursement</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	43,920	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	43,920	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,912	1,873	5,450	39,235	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,912	1,873	5,450	39,235	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.33%

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

24 (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 _____

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		6,491	599,228	605,719		605,719	(242,865)	362,854		1
2	Food Purchase		2,745		2,745		2,745	242,588	245,333		2
3	Housekeeping		9,674	141,101	150,775		150,775		150,775		3
4	Laundry		15,131	94,550	109,681		109,681		109,681		4
5	Heat and Other Utilities			161,997	161,997		161,997	(3,394)	158,603		5
6	Maintenance	65,608	146,889	23,175	235,672		235,672	29,370	265,042		6
7	Other (specify):*			14,673	14,673		14,673		14,673		7
8	TOTAL General Services	65,608	180,930	1,034,724	1,281,262		1,281,262	25,699	1,306,961		8
	B. Health Care and Programs										
9	Medical Director			24,600	24,600		24,600		24,600		9
10	Nursing and Medical Records	2,490,571	159,232	141,402	2,791,205		2,791,205	322,166	3,113,371		10
10a	Therapy	588,441	50,953	52,534	691,928		691,928		691,928		10a
11	Activities	81,863	6,964	15,756	104,583		104,583		104,583		11
12	Social Services	74,799		504	75,303		75,303		75,303		12
13	CNA Training										13
14	Program Transportation			6,400	6,400		6,400		6,400		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,235,674	217,149	241,196	3,694,019		3,694,019	322,166	4,016,185		16
	C. General Administration										
17	Administrative	99,881			99,881		99,881	6,326	106,207		17
18	Directors Fees			381	381		381		381		18
19	Professional Services			15,757	15,757		15,757	26,373	42,130		19
20	Dues, Fees, Subscriptions & Promotions			31,012	31,012		31,012	(1,236)	29,776		20
21	Clerical & General Office Expenses	294,024	22,835	660,494	977,353		977,353	(623,379)	353,974		21
22	Employee Benefits & Payroll Taxes			586,008	586,008		586,008	40,604	626,612		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,910	7,910		7,910	30,359	38,269		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			(625,126)	(625,126)		(625,126)	1,127,205	502,079		26
27	Other (specify):* Franchise Tax							300	300		27
28	TOTAL General Administration	393,905	22,835	676,436	1,093,176		1,093,176	606,552	1,699,728		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,695,187	420,914	1,952,356	6,068,457		6,068,457	954,417	7,022,874		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:

01/01/2016

Ending:

12/31/2016

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			261,100	261,100		261,100	(105,891)	155,209			30
31	Amortization of Pre-Op. & Org.			4,227	4,227		4,227		4,227			31
32	Interest			178,582	178,582		178,582	30,291	208,873			32
33	Real Estate Taxes			310,499	310,499		310,499	(27,796)	282,703			33
34	Rent-Facility & Grounds			943,633	943,633		943,633		943,633			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							38,754	38,754			36
37	TOTAL Ownership			1,698,041	1,698,041		1,698,041	(64,642)	1,633,399			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,233	18,039	155,272		155,272		155,272			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			282,275	282,275		282,275		282,275			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		137,233	300,314	437,547		437,547		437,547			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,695,187	558,147	3,950,711	8,204,045		8,204,045	889,775	9,093,820			45

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

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	(219)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,435)	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	(58)	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	(40,079)	21		18
19	Entertainment				19
20	Contributions	(64)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,372)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(150,292)	21		24
25	Fund Raising, Advertising and Promotional		21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,111)	20		28
29	Other-Attach Schedule	553,675			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 347,045		\$	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)	542,730		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 542,730		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 889,775		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: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Depreciation Adj (Remove Cap Lease Depr)	\$ (105,891)	30	1
2	Reclass Franchise Tax	(300)	33	2
3	Reclass Franchise Tax	300	27	3
4	Real Estate Accrual Adjustment	(27,496)	33	4
5	Back Office Service Fee	(437,507)	21	5
6	Professional Liability Insurance	1,124,569	26	6
7	Reclass Raw Food	(242,865)	1	7
8	Reclass Raw Food	242,865	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	553,675		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	(242,865)	0	0	0	0	0	0	0	0	0	0	(242,865) 1
2	Food Purchase	242,588	0	0	0	0	0	0	0	0	0	0	242,588 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	(3,435)	41	0	0	0	0	0	0	0	0	0	(3,394) 5
6	Maintenance	0	29,370	0	0	0	0	0	0	0	0	0	29,370 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(3,712)	29,411	0	25,699 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	322,166	0	0	0	0	0	0	0	0	0	322,166 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	322,166	0	322,166 16								
	C. General Administration												
17	Administrative	0	6,326	0	0	0	0	0	0	0	0	0	6,326 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	(10,372)	36,745	0	0	0	0	0	0	0	0	0	26,373 19
20	Fees, Subscriptions & Promotions	(2,111)	875	0	0	0	0	0	0	0	0	0	(1,236) 20
21	Clerical & General Office Expenses	(627,942)	4,563	0	0	0	0	0	0	0	0	0	(623,379) 21
22	Employee Benefits & Payroll Taxes	0	40,604	0	0	0	0	0	0	0	0	0	40,604 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	30,359	0	0	0	0	0	0	0	0	0	30,359 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	1,124,569	2,636	0	0	0	0	0	0	0	0	0	1,127,205 26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300 27
28	TOTAL General Administration	484,444	122,108	0	606,552 28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	480,732	473,685	0	954,417 29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westchester Hlth & Rehab Ctr# 0047373

Report Period Beginning:

01/01/2016 Ending:12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(105,891)	0	0	0	0	0	0	0	0	0	0	(105,891)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	30,291	0	0	0	0	0	0	0	0	0	30,291	32
33	Real Estate Taxes	(27,796)	0	0	0	0	0	0	0	0	0	0	(27,796)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	38,754	0	0	0	0	0	0	0	0	0	38,754	36
37	TOTAL Ownership	(133,687)	69,045	0	(64,642)	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)	347,045	542,730	0	889,775	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
<u>Illinois Holdco, LLC</u>	<u>100</u>	<u>Montebello Health Care Center</u>	<u>Hamilton</u>	<u>SSC Equity Holdings LLC</u>		<u>Holding Company</u>
		<u>Nature Trail Health Care Center</u>	<u>Mount Vernon</u>	<u>SSC Administrative Services LLC</u>		<u>Back Office Service</u>
		<u>Odin Health Care Center</u>	<u>Odin</u>	<u>SSC Consulting Services LLC</u>		<u>Consulting Services</u>
		<u>Westchester Health Care Center</u>	<u>Westchester</u>			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>5 Utilities</u>	\$	<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	\$ <u>41</u>	\$ <u>41</u>	<u>1</u>
2	V	<u>6 Repair and Maintenance</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>29,370</u>	<u>29,370</u>	<u>2</u>
3	V	<u>19 Professional Services</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>36,745</u>	<u>36,745</u>	<u>3</u>
4	V	<u>20 Fee, Subscriptions and Promos</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>875</u>	<u>875</u>	<u>4</u>
5	V	<u>10 Nursing & Medical Records</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>322,166</u>	<u>322,166</u>	<u>5</u>
6	V	<u>21 Clerical & Gen Office Exp</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>4,563</u>	<u>4,563</u>	<u>6</u>
7	V	<u>24 Travel & Seminar</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>30,359</u>	<u>30,359</u>	<u>7</u>
8	V	<u>26 Insurance</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>2,636</u>	<u>2,636</u>	<u>8</u>
9	V	<u>36 Depreciation</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>38,754</u>	<u>38,754</u>	<u>9</u>
10	V	<u>17 Communications</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>6,326</u>	<u>6,326</u>	<u>10</u>
11	V	<u>35 Rental and Lease</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>			<u>11</u>
12	V	<u>32 Interest Income/Expense</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>30,291</u>	<u>30,291</u>	<u>12</u>
13	V	<u>22 Payroll Taxes</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>40,604</u>	<u>40,604</u>	<u>13</u>
14	Total		\$			\$ <u>542,730</u>	\$ * <u>542,730</u>	<u>14</u>

* 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:

01/01/2016

Ending:

12/31/2016

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:

01/01/2016

Ending:

12/31/2016

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 Heathcare 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	Austill				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 Heathh & 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

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STATE OF ILLINOIS

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Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 & Rehab Charlotte	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 & Rehab Durham	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 Waynesvi	Waynesville				27
28			Brian Center Health & Rehab Clayton	Clayton				28
29			Brian Center Health & Rehab Brevard	Brevard				29
30			Brian Center Health & Rehab Yanceyville	Yanceyville				30

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Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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								10
11								11
12								12
13								13
14								14
15								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	Seneca				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

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Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 No	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 Nort	Pleasanton				13
14			Retama Manor Nursing Center Pleasanton Sout	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	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

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Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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STATE OF ILLINOIS

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Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

Facility Name & ID Number Westchester Hlth & Rehab Ctr # 0047373 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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:

01/01/2016

Ending: 2/31/2016

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

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

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 (832-467-6984

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			\$ 41	\$		\$ 1
2	6	Repair and Maintenance			29,370			2
3	19	Professional Services			36,745			3
4	20	Fee, Subscriptions and Promos			875			4
5	10	Nursing & Medical Records			322,166			5
6	21	Clerical & Gen Office Exp			4,563			6
7	24	Travel & Seminar			30,359			7
8	26	Insurance			2,636			8
9	36	Drpreiation			38,754			9
10	17	Communications			6,326			10
11	35	Rental and Lease						11
12	32	Interest Income/Expense			30,291			12
13	22	Payroll Taxes			40,604			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				\$ 542,730	\$		\$ 25

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

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

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

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

2015 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 6984

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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>351,314.00</u>	\$ <u>351,314.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>351,314.00</u></u>	\$ <u><u>351,314.00</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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).

NA

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 contains 'TOTALS'.

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	2005	6,484		10			9
10	Concrete Sidewalk 1/3 downpayment	2005	2005	1,628	131	12	131		10
11	12.5 Ton RTU - Kitchen - Balance	2005	2005	6,484		10			11
12	Concrete Sidewalk	2005	2005	3,389		11.5			12
13	Plumbing Project	2005	2005	4,750	379	11.8	379		13
14	Plumbing Repairs	2005	2005	10,000	797	11.8	797		14
15	Instl Door w/Closer - Exit Device	2005	2005	2,576	211	11.5	211		15
16	Mixing Valve Spout - Kitchen	2005	2005	2,207	181	11.5	181		16
17	Dry Sprinkler System Repair	2005	2005	2,159	177	11.5	177		17
18	Repair Dry Sprinkler System	2005	2005	1,893	155	11.5	155		18
19	Heat Pump	2005	2005	1,255	103	11.5	103		19
20	Double Swing Gates - Dumpster	2005	2005	1,226		8			20
21	Heat - Shower Room	2005	2005	19,832		10			21
22	Remove Carpet and Install Tile	2005	2005	37,384		10			22
23									23
24	Emergency Generator	2006	2006	2,907		11.25			24
25	Paint Project - Deposit	2006	2006	4,700		5			25
26	16: 2" Wood Blinds	2006	2006	1,647		5			26
27	Front Automatic Doors - 50% Deposit	2006	2006	7,122	178	10	178		27
28	13: Cubicle Curtains W/Mesh	2006	2006	2,037		5			28
29	16: Single Rod Valances	2006	2006	1,623		5			29
30	Paint and Light Fixtures	2006	2006	7,050	611	10.5	611		30
31	16: Wood Blinds	2006	2006	1,718		5			31
32	15: Cubicle Curtains W/Mesh	2006	2006	2,157		5			32
33	16: Single Rod Valances	2006	2006	1,631		5			33
34	Painting Patient Rooms	2006	2006	3,889		5			34
35	Painting Facility- Down Pmt	2006	2006	4,000		5			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:

01/01/2016 Ending: 12/31/2016

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	\$	\$	\$	37
38	Painting Resident Rooms	2006	4,400		5				38
39	New Carpet - Admissions Office	2006	4,737		5				39
40	New Carpet - Admissions Office	2006	148		5				40
41	Repair Fire Alarm System	2006	1,778	45	10	45			41
42	Cove Base/Refurb	2006	2,462		5				42
43	Use Tax - Cove Base/Refurb	2006	171		5				43
44	Painting Resident Rooms - Balance	2006	6,700		5				44
45	Paint for Refurb	2006	637		5				45
46	Paint for Refurb	2006	499		5				46
47	Paint for Refurb	2006	360		5				47
48	Crash Rails	2006	550	49	10.25	49			48
49	Crash Rails for Walls	2006	2,961	259	10.42	259			49
50									50
51	13: Wall Boxes/Sconce Lights	2007	269	22	10	22			51
52	Use Tax - 13: Wall Boxes/Sconce Lights	2007	21	2	10	2			52
53	Carpet/Labor	2007	4,440		5				53
54	Front Automatic Doors - Balance	2007	7,122	297	10	297			54
55	10: Overbed Lights	2007	1,689	113	10	113			55
56	Use Tax - 10: Overbed Lights	2007	131	9	10	9			56
57	59: Wall Boxes/Sconce Lights	2007	1,675	112	10	112			57
58	Use Tax - 59: Wall Boxes/Sconce Lights	2007	127	8	10	8			58
59	Remodel North & South Front Exit	2007	1,049	98	9.75	98			59
60	Heat/Cool Unit	2007	959	89	9.83	89			60
61	Connect Kit Heat/AC Unit	2007	46	4	9.83	4			61
62	Repair to Walk In Freezer	2007	5,177	475	9.92	475			62
63	Fire Sprinkler Repair	2007	2,826	259	9.92	259			63
64	Design Fee	2007	2,900	261	10.08	261			64
65	Design Fee	2007	225	20	10.08	20			65
66	50 Overbed Lights and Wall Sconces	2007	8,572	767	10.16	767			66
67	50 Overbed Lights and Wall Sconces	2007	664	59	10.16	59			67
68	61 Mount Wall Box Sconces	2007	1,741	160	9.92	160			68
69	61 Mount Wall Box Sconces	2007	135	12	9.92	12			69
70	TOTAL (lines 4 thru 69)		\$ 210,809	\$ 6,043		\$ 6,043	\$	\$	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:

01/01/2016 Ending: 12/31/2016

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	\$ 6,043		\$ 6,043			1
2	29 Oxygen Concentrators	2007	15,536	1,448	9.75	1,448			2
3	29 Oxygen Concentrators	2007	1,204	112	9.75	112			3
4	Cr: Void Ck Village Westchester	2007	(1,049)	(98)	9.75	(98)			4
5	Permit Fee to Remode;	2007	1,049	99	9.66	99			5
6	Connection Kit Heat/Cool Unit	2007	46	4	9.83	4			6
7	2 Connect Kits Heat/AC Units	2007	92	8	9.83	8			7
8	Cr on Heat/AC Unit	2007	(891)	(83)	9.75	(83)			8
9	4 Heat/Cool Units	2007	3,564	329	9.83	329			9
10	4 Power Conn Kits Heat/AC Units	2007	201	19	9.83	19			10
11	Furnace Repair	2007	1,380	128	9.83	128			11
12	Heat Repair	2007	3,033		10				12
13	Repair 8 Heat AC Units	2007	11,700		10				13
14	Boiler Repair	2007	661	62	9.75	62			14
15	Remodel North/Southwest Exits	2007	53,930	5,114	9.58	5,114			15
16	AC Unit	2007	4,835	322	10	322			16
17	AC Unit	2007	375	25	10	25			17
18	Water Heater	2007	1,866	174	9.75	174			18
19	Stainless Steel End Wall Kitchen	2007	1,261	123	9.41	123			19
20									20
21	2:AC Compressor Units	2008	9,874	970	9.25	970			21
22	Steel Door	2008	1,675	169	9	169			22
23	Furnace 50% Deposit	2008	2,759	286	8.75	286			23
24	Compressor For Cooling System	2008	3,993	389	9.33	389			24
25	Furnace -Final Payment	2008	2,759	289	8.66	289			25
26	Steel Door - Balance	2008	1,675	174	8.75	174			26
27	2: Zonline Heat/Cool Units	2008	1,341	141	8.66	141			27
28	Heat Exchanger for Boiler	2008	7,510	794	8.58	794			28
29	6: Zonline heat/Cool Units	2008	3,636		5				29
30	AT&T Circuit Conversion	2008	32,788	3,641	8.16	3,641			30
31	AT&T Circuit Conversion	2008	6,306	715	8	715			31
32	Blower Assembly	2008	3,511	398	8	398			32
33									33
34	TOTAL (lines 1 thru 33)		\$ 387,429	\$ 21,795		\$ 21,795			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:

01/01/2016 Ending: 12/31/2016

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	\$ 21,795		\$ 21,795	\$	\$	1
2	3: Zoneline Heat/Cool Units	2009	1,999	244	7.42	244			2
3	Condenser fan motor	2009	8,348	1,009	7.5	1,009			3
4	2: Zoneline Heat/Cool Units	2009	1,333	165	7.34	165			4
5	Front Entry Paint	2009	6,241		5				5
6	Replace Gaas Valve & Thermometer	2009	2,500	323	7	323			6
7									7
8	2: Zoneline Heat/Cool Units	2010	1,346	174	7	174			8
9	Wanderguard	2010	2,744	351	7	351			9
10	Attic Sprikler System	2010	33,760	4,642	6.66	4,642			10
11	Replaced Heat Exchanger	2010	8,224	1,077	6.92	1,077			11
12	Rplc Furnace Thermostate & Sensor	2010	2,512	329	6.92	329			12
13	Zoneline Heat/Cool Unit	2010	568		5				13
14	3: Zoneline Heat/Cool Units	2010	1,968	264	6.75	264			14
15	Attic Sprikler System	2010	52,686	7,244	0.92	7,244			15
16	Attic Sprikler System	2010	47,056	6,470	6.92	6,470			16
17	Rplc Bearing Assembly & Blower Motor	2010	6,357	842	6.83	842			17
18	Attic Sprikler System	2010	8,025	1,016	6.92	1,016			18
19	Site Survey	2010	225	33	6.16	33			19
20	Compressor Unit	2010	3,102	449	6.16	449			20
21	Rplc Water Heater	2010	10,077	1,459	6.25	1,459			21
22	Replace Tempering Valves	2010	4,740	705	6.08	705			22
23									23
24	Maglock	2011	798	114	6.34	114			24
25	3: Zoneline Heat/Cool Units	2011	2,202		6				25
26	Facility Building Sign	2011	2,203	389	6.5	389			26
27									27
28	Dry Pendant Sprinkler Heads	2012	5,598	1,101	5	1,101			28
29	3: Zoneline Heat/Cool Units	2012	2,343	485	5	485			29
30	Garbage Disposal	2012	756	168	5	168			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 605,140	\$ 50,848		\$ 50,848	\$	\$	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:

01/01/2016 Ending: 12/31/2016

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	\$ 50,848		\$ 50,848	\$	\$	1
2	Mixing Valves	2013	5,790	1,478	44	1,478			2
3	Heat Draft Inducer Motor	2013	4,043	1,032	4	1,032			3
4	Aluminum Light Pole	2013	3,200	784	4	784			4
5	Inducer	2013	3,571	912	3.75	912			5
6	5: Duct Detectors	2013	3,035	809	3.75	809			6
7	Inducer - Credit Memo	2013	(689)	(180)	3.83	(180)			7
8	A/C Motor Kitchen Area	2013	1,642	438	3.75	438			8
9	Relays for Duct Smoke Detector	2013	1,000	273	3.67	273			9
10	19: Damper Actuators	2013	4,370	1,220	3.58	1,220			10
11	12: Damper Actuators	2013	1,338	373	3.58	373			11
12	Generator Transfer Switch	2013	4,722	1,318	3.58	1,318			12
13	12 Damper Actuators	2013	1,338	373	3.58	373			13
14	A/C Compressor Unit #1	2013	3,668	1,048	3.5	1,048			14
15	A/C Compressor & Condenser Fan	2013	3,580	1,048	3.42	1,048			15
16	Hot Water Booster Heater - Dishwasher	2013	2,529	740	3.42	740			16
17	7: Exhaust Vents	2013	1,332	410	3.25	410			17
18	Motor for Unit #8	2013	2,268	698	3.25	698			18
19	Bearing Assembly Water Heater	2013	2,960	911	3.25	911			19
20	Gas Valve and Ignifion Control	2013	2,294	724	3.17	724			20
21									21
22	PTAC Unit	2014	847	282	3	282			22
23	PTAC Unit	2014	847	282	3	282			23
24	A/C Heating Units 9A & 9B	2014	14,770	5,213	3	5,213			24
25	3: Exhaust Fan Motors	2014	3,235	332	9.75	332			25
26	Condensing Unit for # 3 A/C	2014	3,157	265	12	265			26
27	A/C Condenser Fan Motors	2014	1,766	148	12	148			27
28	Mixing Valve Cartridge	2014	2,535	254	10	254			28
29	Split A/C System- Laundry & Hall	2014	14,370	1,437	10	1,437			29
30	Condesner for Walkin Freezer	2014	7,790	658	11.83	658			30
31	Door Closer & Hing System	2014	3,074	262	11.83	262			31
32	10: LCN 4040 24v Door Holder	2014	7,329	733	10	733			32
33	11: Aluminum 24 LCN Closer Door	2014	7,376	637	11.58	637			33
34	TOTAL (lines 1 thru 33)		\$ 724,227	\$ 75,760		\$ 75,760	\$	\$	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:

01/01/2016 Ending: 12/31/2016

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	\$ 75,760		\$ 75,760	\$	\$	1
2	Fan Guard on Walk In Cooler	2015	1,956	196	10	196			2
3	Installed LP Switch on A/C Units	2015	2,227	223	10	223			3
4	Replaced Water Level Probe n Ice Machine	2015	2,447	245	10	245			4
5	Unit Pump on Boiler/Furnace #1	2015	3,185	318	10	318			5
6	Unit Pump on Boiler/Furnace #2	2015	2,650	265	10	265			6
7	R22 Condensor Replacement on A/C	2015	2,325	211	11	211			7
8	Water Heater Part - Heat	2015	643	64	10	64			8
9	Compressor for A/C Unit	2015	2,325	211	11	211			9
10	Install 15 door closers and magnets	2015	4,906	490	10	490			10
11	CMBS Asphalt Pavement	2015	25,125	3,141	8	3,141			11
12	Install Parking Lot Tactile & Sign	2015	2,000	171	11.67	171			12
13	Wood Window and Doors	2015	5,958	511	11.67	511			13
14	Shower Room Renovation - ADA Bariatric Shower Rebuilds	2015	55,600	5,026	11.33	5,026			14
15	Install New Control Board Blower on Furnace	2015	2,947	258	11.41	258			15
16	Install Gas Valve on Furnace	2015	1,488	149	10	149			16
17	Replaced Air Curtain on Freezer	2015	895	79	11.33	79			17
18	Walk in Freezer Aluminum Plate	2015	1,795	161	11.16	161			18
19	Norstar Phone System Install	2015	6,179	618	10	618			19
20	PTAC Resistance Heater	2015	767	153	5	153			20
21									21
22	Replaced Bearing and Shaft	2016	3,165	573	11.5	573			22
23	Circulating Pump	2016	2,707	383	10	383			23
24	Motor for Walk in Freezer	2016	5,367	702	10.8	702			24
25	Valves, Coupling and Thermometer	2016	6,185	876	10	876			25
26	Door Closer	2016	1,777	117	10	117			26
27	Data Board for Water Heater	2016	1,488	161	10	161			27
28	Kitchen Hot Water Compliance	2016	6,443	524	10.1	524			28
29	PTAC Resistance Heater	2016	1,468	245	5	245			29
30	Remove and Replace all plumbing, electrical and shower walls	2016	12,931	1,861	11	1,861			30
31	PTAC Resistance Heater	2016	734	110	5	110			31
32	Mixing Valve Cartridges	2016	3,276	218	10	218			32
33	PTAC Resistance Heater	2016	734	73	5	73			33
34	TOTAL (lines 1 thru 33)		\$ 895,920	\$ 94,093		\$ 94,093	\$	\$	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 12E, Carried Forward		\$ 895,920	\$ 94,093		\$ 94,093	\$	\$	1
2	Upgrading Landscape	2016	12,000	605		605			2
3	Installed New Mini Split AC	2016	10,294	436		436			3
4	Installed Backflow Fire Device	2016	12,167	516		516			4
5	Replaced Radiator Generator	2016	4,542	155		155			5
6	Garbage Disposal 2 hp	2016	1,651	55		55			6
7	5 PTACs	2016	3,671	61		61			7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 940,245	\$ 95,921		\$ 95,921	\$	\$	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:

01/01/2016

Ending:

12/31/2016

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	\$ 471,695	\$ 55,002	\$ 55,002	\$		\$ 442,253	71
72	Current Year Purchases	66,785	4,286	4,286			4,286	72
73	Fully Depreciated Assets	(3,047)						73
74								74
75	TOTALS	\$ 535,433	\$ 59,288	\$ 59,288	\$		\$ 446,539	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)	\$ 1,475,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,209	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,209	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)	\$ 446,539	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.

Facility Name & ID Number

Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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:	1988	120	10/11/2013	\$ 943,633	12		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 943,633			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.	<u>/2017</u>	\$ <u>1,199,522</u>
13.	<u>/2018</u>	\$ <u>1,199,522</u>
14.	<u>/2019</u>	\$ <u>1,199,522</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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-3	4168	hrs	\$ 194,396		\$	\$	4,168	\$ 194,396	1
2	Licensed Speech and Language Development Therapist	10a-3	1266	hrs	62,377				1,266	62,377	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-3	7911	hrs	329,418				7,911	329,418	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				137,233		137,233	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				\$ 586,191		\$	\$ 137,233	13,345	\$ 723,424	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.

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	(3,830)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,891,095		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,874		6
7	Other Prepaid Expenses	5,996		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,896,435	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	18,178		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,440,245		15
16	Equipment, at Historical Cost	535,433		16
17	Accumulated Depreciation (book methods)	(1,266,117)		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):	200		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,727,939	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,624,374	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 272,819	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	439,800		30
31	Accrued Taxes Payable (excluding real estate taxes)	(790)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	351,314		32
33	Accrued Interest Payable			33
34	Deferred Compensation	42,737		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	204,038		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,309,918	\$	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>	10,237,578		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,237,578	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,547,496	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (923,123)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,624,373	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,013,285)	1
2	Restatements (describe):	512,732	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,500,553)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	577,430	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)	\$ 577,430	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)	\$ (923,123)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 20,734,378	1
2	Discounts and Allowances for all Levels	(13,656,803)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,077,575	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,562,211	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,562,211	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	570	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	120,546	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,035	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 140,151	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>	1,538	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,538	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,781,475	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,281,262	31
32	Health Care	3,694,019	32
33	General Administration	1,093,176	33
B. Capital Expense			
34	Ownership	1,698,041	34
C. Ancillary Expense			
35	Special Cost Centers	155,272	35
36	Provider Participation Fee	282,275	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,204,045	40
41	Income before Income Taxes (line 30 minus line 40)**	577,430	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 577,430	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,114,859	44
45	Private Pay - Net Inpatient Revenue	785,274	45
46	Medicare - Net Inpatient Revenue	955,159	46
47	Other-(specify) <u>HMO/Insurance</u>	12,126	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	210,157	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,077,575	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: 01/01/2016

Ending: 12/31/2016

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	1,776	1,907	\$ 99,300	\$ 52.07	1
2	Assistant Director of Nursing	1,480	1,672	66,776	39.94	2
3	Registered Nurses	8,500	9,133	292,120	31.99	3
4	Licensed Practical Nurses	34,662	37,588	1,053,971	28.04	4
5	CNAs & Orderlies	63,509	68,469	978,404	14.29	5
6	CNA Trainees					6
7	Licensed Therapist	10,673	13,345	588,441	44.09	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,216	2,339	55,718	23.82	9
10	Activity Assistants	2,007	2,206	26,145	11.85	10
11	Social Service Workers	3,001	3,734	74,799	20.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,939	3,095	65,608	21.20	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,784	1,960	99,641	50.84	20
21	Assistant Administrator					21
22	Other Administrative	6,218	6,863	193,914	28.25	22
23	Office Manager					23
24	Clerical	5,144	5,467	100,350	18.36	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,909	157,778	\$ 3,695,187 *	\$ 23.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 355,905	1-3	35
36	Medical Director	24,600	9-3	36
37	Medical Records Consultant	4,800	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	9,405	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	259	10a-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	14,075	11-3	44
45	Social Service Consultant	504	12-3	45
46	Other(specify)	71,488	10-3	46
47	XRay and Laboratory	16,414	39-3	47
48	Dentist/Physician/Psychiatrist	188	39-3	48
49	TOTAL (lines 35 - 48)	\$ 497,638		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		
Kevin Meals	Administrator	0	\$ 99,881	Workers' Compensation Insurance	\$ 93,827	IDPH License Fee	\$		
				Unemployment Compensation Insurance	77,702	Advertising: Employee Recruitment	7,384		
				FICA Taxes	274,688	Health Care Worker Background Check	6,850		
				Employee Health Insurance	133,650	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	747		
				Life Insurance	2,774	Professional Dues	11,390		
				Other Benefits	3,367	Other Licenses	2,530		
				Home Office Payroll Taxes	40,604	Fees, Subscriptions and Promos	875		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,881	TOTAL (agree to Schedule V, line 22, col.8)		\$ 626,612	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,776
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$ 1,591	
							In-State Travel	2,374	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	3,946	
C. Professional Services				TOTAL			Home Office Allocation		
Vendor/Payee	Type		Amount					30,359	
Bradley Assoc			\$ 900				Entertainment Expense	()	
Burgeon Legal Group	Legal		10,372				(agree to Sch. V, line 24, col. 8)		
Cass Information Systems			1,488				TOTAL	\$ 38,270	
Compsych			1,107						
Ecova Inc	Utility Management		81						
Equifax			528						
LexisNexis			129						
National Research			1,152						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 15,757						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Westchester Hlth & Rehab Ctr

0047373

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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 \$11,390
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,478 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. \$ 282,275
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? NA
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. NA
Attach invoices and a summary of services for all architect and appraisal fees