

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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>0047340</u></p> <p>Facility Name: <u>SSC Hamilton Ooperating Company LLC dba Montebello Health Care Center</u></p> <p>Address: <u>1599 Keokuk Street</u> <u>Hamilton</u> <u>62341</u> Number City Zip Code</p> <p>County: <u>Hancock</u></p> <p>Telephone Number: <u>271 847 3931</u> Fax # <u>217 847 2067</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>01/01/2017</u> to <u>12/31/2017</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>SVP Operations Finance</u></td> </tr> <tr> <td style="width:15%; 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>SVP Operations Finance</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>SVP Operations Finance</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number SSC Hamilton Operating Company LLC dba Montebello Health Care Center

0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,735	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,864	4,113	4,174	23,151	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,864	4,113	4,174	23,151	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.63%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 139 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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number SSC Hamilton Operating Company LLC db # 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		1,122	323,017	324,139		324,139	(87,048)	237,091		1
2	Food Purchase		1,882		1,882		1,882	86,970	88,852		2
3	Housekeeping		2,510	98,220	100,730		100,730		100,730		3
4	Laundry		4,640	65,484	70,124		70,124		70,124		4
5	Heat and Other Utilities			109,412	109,412		109,412	(4,365)	105,047		5
6	Maintenance	44,344	73,243	12,958	130,545		130,545	12,799	143,344		6
7	Other (specify):*			9,369	9,369		9,369		9,369		7
8	TOTAL General Services	44,344	83,397	618,460	746,201		746,201	8,356	754,557		8
	B. Health Care and Programs										
9	Medical Director			10,356	10,356		10,356		10,356		9
10	Nursing and Medical Records	1,135,779	116,495	402,933	1,655,207		1,655,207	136,704	1,791,911		10
10a	Therapy	410,378	32,553	59,456	502,387		502,387		502,387		10a
11	Activities	33,596	4,708	4,529	42,833		42,833		42,833		11
12	Social Services	44,623		2,797	47,420		47,420		47,420		12
13	CNA Training										13
14	Program Transportation	29,928	5,875	3,600	39,403		39,403		39,403		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,654,304	159,631	483,671	2,297,606		2,297,606	136,704	2,434,310		16
	C. General Administration										
17	Administrative	96,048			96,048		96,048	2,470	98,518		17
18	Directors Fees			893	893		893		893		18
19	Professional Services			9,163	9,163		9,163	11,296	20,459		19
20	Dues, Fees, Subscriptions & Promotions			65,451	65,451		65,451	232	65,683		20
21	Clerical & General Office Expenses	104,557	19,095	483,870	607,522		607,522	(426,490)	181,032		21
22	Employee Benefits & Payroll Taxes			330,890	330,890		330,890	19,045	349,935		22
23	Inservice Training & Education										23
24	Travel and Seminar			27,523	27,523		27,523	12,961	40,484		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			101,269	101,269		101,269	(81,846)	19,423		26
27	Other (specify):* Franchise Tax			300	300		300		300		27
28	TOTAL General Administration	200,605	19,095	1,019,359	1,239,059		1,239,059	(462,332)	776,727		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,899,253	262,123	2,121,490	4,282,866		4,282,866	(317,272)	3,965,594		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			107,112	107,112		107,112	(84,923)	22,189			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			223,982	223,982		223,982	11,963	235,945			32
33	Real Estate Taxes			62,881	62,881		62,881	(2,143)	60,738			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			600	600		600		600			35
36	Other (specify):*							17,904	17,904			36
37	TOTAL Ownership			394,575	394,575		394,575	(57,199)	337,376			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,683	21,820	97,503		97,503		97,503			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,248	169,248		169,248		169,248			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		75,683	191,068	266,751		266,751		266,751			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,899,253	337,806	2,707,133	4,944,192		4,944,192	(374,471)	4,569,721			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				4
5	Telephone, TV & Radio in Resident Rooms	(4,381)	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	(78)	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	(15)	21		18
19	Entertainment	(86)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,197)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(186,354)	21		24
25	Fund Raising, Advertising and Promotional	(14,193)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(115)	20		28
29	Other-Attach Schedule	(291,937)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (498,356)		\$	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)	230,135		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 230,135		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (268,221)		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	

SSC Hamilton Operating Company LLC dba Montebello Health Care Center

ID# 0047340

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Back Office Services	\$ (227,443)	21	1
2	Professional Liability Insurance Adjustment	(83,678)	26	2
3	Depreciaton Adjustment	(84,923)	30	3
4	Reclass Raw Food Expense	(87,048)	1	4
5	Reclass Raw Food Expense	87,048	2	5
6	Real Estate Tax Adjustment	(2,143)	33	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(398,187)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SSC Hamilton Operating Company LLC dba Montebello H

0047340

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	(87,048)	0	0	0	0	0	0	0	0	0	0	(87,048)	1
2	Food Purchase	86,970	0	0	0	0	0	0	0	0	0	0	86,970	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,381)	16	0	0	0	0	0	0	0	0	0	(4,365)	5
6	Maintenance	0	12,799	0	0	0	0	0	0	0	0	0	12,799	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,459)	12,815	0	8,356	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	136,704	0	0	0	0	0	0	0	0	0	136,704	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	136,704	0	136,704	16								
	C. General Administration													
17	Administrative	0	2,470	0	0	0	0	0	0	0	0	0	2,470	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,197)	12,493	0	0	0	0	0	0	0	0	0	11,296	19
20	Fees, Subscriptions & Promotions	(115)	347	0	0	0	0	0	0	0	0	0	232	20
21	Clerical & General Office Expenses	(428,005)	1,515	0	0	0	0	0	0	0	0	0	(426,490)	21
22	Employee Benefits & Payroll Taxes	0	19,045	0	0	0	0	0	0	0	0	0	19,045	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(86)	13,047	0	0	0	0	0	0	0	0	0	12,961	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(83,678)	1,832	0	0	0	0	0	0	0	0	0	(81,846)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(513,081)	50,749	0	(462,332)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(517,540)	200,268	0	(317,272)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SSC Hamilton Operating Company LLC dba Montebello H # 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(84,923)	0	0	0	0	0	0	0	0	0	0	(84,923) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	11,963	0	0	0	0	0	0	0	0	0	11,963 32
33	Real Estate Taxes	(2,143)	0	0	0	0	0	0	0	0	0	0	(2,143) 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	17,904	0	0	0	0	0	0	0	0	0	17,904 36
37	TOTAL Ownership	(87,066)	29,867	0	(57,199) 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)	(604,606)	230,135	0	(374,471) 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
Illinois Holdco 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 LLC		Consulting Services
		Westchester Health Care Center	Westchester			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	5 Utilities	\$	SSC Equity Holdings LLC	100.00%	\$ 16	\$	16	1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	12,799		12,799	2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	12,493		12,493	3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	347		347	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	136,704		136,704	5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	1,515		1,515	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	13,047		13,047	7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	1,832		1,832	8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	17,904		17,904	9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	2,470		2,470	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%	11,963		11,963	12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	19,045		19,045	13
14	Total		\$			\$ 230,135	\$ *	230,135	14

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

Facility Name & ID Number SSC Hamilton Operating Company LLC dba Montebello Health Care # 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 SSC Hamilton Operating Company LLC dba Montebello Health Care # 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

Facility Name & ID Number SSC Hamilton Ooperating Company LLC dba Montebello Health Care# 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Waynesvi	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

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STATE OF ILLINOIS

Facility Name & ID Number SSC Hamilton Ooperating Company LLC dba Montebello Health Care# 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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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STATE OF ILLINOIS

Facility Name & ID Number SSC Hamilton Ooperating Company LLC dba Montebello Health Care# 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

Facility Name & ID Number SSC Hamilton Ooperating Company LLC dba Montebello Health Care# 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 SSC Hamilton Operating Company LLC dl # 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 SSC Hamilton Operating Company LLC dba Montebello # 0047340 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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			\$	\$		\$ 16	1
2	6	Repair and Maintenance						12,799	2
3	19	Professional Services						12,493	3
4	20	Fee, Subscriptions and Promos						347	4
5	10	Nursing & Medical Records						136,704	5
6	21	Clerical & Gen Office Exp						1,515	6
7	24	Travel & Seminar						13,047	7
8	26	Insurance						1,832	8
9	36	Drpreiation						17,904	9
10	17	Communications						2,470	10
11	35	Rental and Lease							11
12	32	Interest Income/Expense						11,963	12
13	22	Payroll Taxes						19,045	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				\$	\$		\$ 230,135	25

Facility Name & ID Number SSC Hamilton Operating Company LLC db

0047340

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$	72,717	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	70,574	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,143)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	62,881	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	60,738	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	62,762	8
	2013	62,828	9
	2014	67,047	10
	2015	68,287	11
	2016	70,574	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SSC Hamilton Operating Company LLC dba Montebello Hc COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0047340

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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-29-999-119</u>	<u>Lot B Sub (Ex 2A SE Corner &</u>	\$ <u>70,574.00</u>	\$ <u>70,574.00</u>
2. _____	<u>377 x 145 SW Corner) NE</u>	\$ _____	\$ _____
3. _____	<u>Montebello 5-8 12-29B 11-538</u>	\$ _____	\$ _____
4. _____	<u>12-29-255-011 Keokuk Street</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>70,574.00</u></u>	\$ <u><u>70,574.00</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	139	2005	1974	\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	6 Ton 230V RTU		2005	27,558		10			27,558	9
10	Four Heat Run Duct System		2005	1,500		11.5			1,500	10
11	Repair Damaged Phone System		2005	1,576		10			1,576	11
12	Watermain Repair		2005	8,682		11.5			8,682	12
13	Retaining Wall - Partial Payment		2005	6,359		11.5			6,359	13
14	Fire Alarm Control Panel		2005	2,404		10			2,404	14
15	Construct Walkway Cover		2005	5,022		11.5			5,022	15
16	Leveled Ground around Stairway		2005	525		11.5			525	16
17	Fire Alarm System		2005	1,824		10			1,824	17
18	Install New Handrails		2005	415		11.5			415	18
19	Fire Alarm Control Panel		2005	872		10			872	19
20	Drywall Repairs - Water Break		2005	3,975		11.5			3,975	20
21	16: Toilet and Shower Floors		2005	10,166		11.3			10,166	21
22	Front Entry Concrete		2005	7,081		11.3			7,081	22
23	6: Smoke Detectors		2005	1,480		10			1,480	23
24	Relays for Emergency Lights		2005	2,776		11.3			2,776	24
25										25
26	119 Gallon Electric Water Heater		2006	4,362		10			4,362	26
27	Use Tax: Water Heater		2006	268		10			268	27
28	Install Water Heater		2006	659		10			659	28
29	Install Electrical Water Heater		2006	384		10			384	29
30	42' Sidewalk - Outside Patio		2006	1,820		10.175			1,820	30
31	Sprinkler		2006	2,296		10.175			2,296	31
32	Repair Sprinkler System		2006	6,893		10			6,893	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Deposit - Vinyl Floor	2007	\$ 1,928	\$	9.25	\$	\$	\$ 1,928	37
38	Vinyl Flooring	2007	2,153		9.08			2,153	38
39	Replace AC Compressor - Laundry	2007	1,663		9.08			1,663	39
40	Sprinkler System Install	2007	1,744		9.16			1,744	40
41	Vinyl Flooring 2 Shower/Bathroom	2007	475		9			475	41
42									42
43									43
44	Backflow Devices - Sprinkler System	2008	21,646		9			21,646	44
45	Generator Water Pump	2008	4,412		8.58			4,412	45
46	Foundation Upgrade	2008	5,340		8.5			5,340	46
47	Sealed 3 Cracks Below Windows	2008	1,400		8.66			1,400	47
48	Water Abatement & Concrete Work	2008	2,670		8.41			2,670	48
49	Fire Alarm Maintenance	2008	3,191		8.25			3,191	49
50	Genset Wiring	2008	1,903		8.25			1,903	50
51	Generatro Remote Annunicator	2008	2,349		8.25			2,349	51
52	Dry System Accelerator	2008	8,020		8.25			8,020	52
53	Water Abatement & Concrete Work	2008	2,670		8.25			2,670	53
54									54
55									55
56	Wanderguard Monitor	2009	880		7.3			880	56
57	Concrete Sidewalk	2009	3,190		7.08			3,190	57
58	Anti Scald Mixing Valve	2009	1,074		7.25			1,074	58
59									59
60	Basement Door Locks	2010	2,263		6.92			2,263	60
61	Fire Alarm/Air Handler Connection	2010	5,363		7.83			5,363	61
62	Wanderguard System Credit	2010	(880)		6.75			(880)	62
63	Recepticles in 20 Rooms	2010	6,800		6.67			6,800	63
64	Intumescent Firestop	2010	18,880		6.58			18,880	64
65	5 Ton Central Air Conditioner	2010	4,580		6.34			4,580	65
66	Replaced Roof Membrane	2010	4,800		6			4,800	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 207,409	\$		\$	\$	\$ 207,409	70

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 207,409	\$		\$	\$	\$ 207,409	1
2	Fire Alarm / Air Handler	2011	348		10			348	2
3	Install 2 Roof Top Units	2011	15,694		10			15,694	3
4	20 Wood Blinds	2011	2,964		5			2,964	4
5	17 Room Signs	2011	627		5			627	5
6	Shirred Valances and Rods	2011	2,912		5			2,912	6
7	Replace Tile & Vinyl flooring, walls, plumbing, & paint in 15 resid	2011	138,295		15			138,295	7
8	Replace electrical wiring and crown molding	2011	8,467		15			8,467	8
9									9
10	2 3 Ton Min Split Systems	2012	13,456		5			13,456	10
11	Commercial Disposal	2012	1,042		5			1,042	11
12									12
13	Stair Rail Panels	2013	1,991		4			1,991	13
14	Electrical for New Range	2013	1,285		3.75			1,285	14
15	NW Wing RTU Evaporator Coil	2013	2,986		3.4			2,986	15
16	Walk In Cooler Compressor	2013	1,193		3.4			1,193	16
17	Nortstar Phone System	2013	15,745		3.4			15,745	17
18	A/C Blower Motor	2013	959		3.25			959	18
19									19
20	Polycom Phones	2014	521		3			521	20
21									21
22	CMBS Parking Curbs and Signs	2015	4,330		2			4,330	22
23	CMBS Strobe Fire Alarm Device	2015	2,000	200	10	200		650	23
24	CMBS Toilet Rooms	2015	1,400	120	11.66	120		390	24
25	CMBS Windows and Frame Replace	2015	1,320	113	11.66	113		368	25
26	Electrical Conduit	2015	2,064	166	12.42	166		665	26
27	50 ESA36-5, 3 Phase U	2015	6,418	1,284	5	1,284		3,637	27
28	Fire Panel	2015	2,387	239	5	239		597	28
29									29
30	Mounting Gasket for Commercial Disposal	2016	30	6	5	6		10	30
31	Commercial Disposal	2016	1,079	216	5	216		378	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 436,922	\$ 2,344		\$ 2,344	\$	\$ 426,919	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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 436,922	\$ 2,344		\$ 2,344	\$	\$ 426,919	1
2	Demo and rebuild shower room - drywall, floors, plumbing	2017	27,238	1,967	15	1,967		1,967	2
3	Cleanspace liners, DryTrak, &labor for basement drainage	2017	4,475	131	15	131		131	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 468,635	\$ 4,442		\$ 4,442	\$	\$ 429,017	34

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

Facility Name & ID Number SSC Hamilton Operating Company LLC dba Mont # 0047340

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	\$ 279,017	\$ 16,053	\$ 16,053	\$		\$ 207,946	71
72	Current Year Purchases	17,052	1,694	1,694			1,694	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 296,069	\$ 17,747	\$ 17,747	\$		\$ 209,640	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)	\$ 764,704	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,189	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,189	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)	\$ 638,657	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>139</u>	<u>10/16/2013</u>	\$	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		139		\$			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>/2018</u>	\$ <u>1,136,460</u>
13.	<u>/2019</u>	\$ <u>1,136,460</u>
14.	<u>/2020</u>	\$ <u>1,136,460</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.

Facility Name & ID Number

SSC Hamilton Operating Company LLC dba Montebello Health Care (# 0047340 Report Period Beginning:

01/01/2017 Ending:

12/31/2017

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	2915 hrs	\$ 104,213		\$	\$	2,915	\$ 104,213	1
2	Licensed Speech and Language Development Therapist	10a-03	1312 hrs	62,607				1,312	62,607	2
3	Licensed Recreational Therapist	10a-03	hrs	0						3
4	Licensed Physical Therapist	10a-03	5873 hrs	243,558				5,873	243,558	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				75,683		75,683	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			\$ 410,378		\$	\$ 75,683	10,100	\$ 486,061	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 SSC Hamilton Operating Company LLC dba Montebello I # 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	\$ 550	\$	1
2	Cash-Patient Deposits	50,840		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	639,379		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	292		6
7	Other Prepaid Expenses	3,709		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 694,770	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,937		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,168,635		15
16	Equipment, at Historical Cost	296,069		16
17	Accumulated Depreciation (book methods)	(744,907)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,725,734	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,420,504	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 243,729	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	218,067		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,706		32
33	Accrued Interest Payable			33
34	Deferred Compensation	2,833		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	34,850		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 562,185	\$	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>	1,623,437		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,623,437	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,185,622	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 234,882	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,420,504	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 636,338	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 636,338	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(401,456)	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)	\$ (401,456)	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)	\$ 234,882	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SSC Hamilton Operating Company LLC dba Mon # 0047340 Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	\$ 18,468,680	1
2	Discounts and Allowances for all Levels	(15,031,503)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,437,177	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	991,874	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 991,874	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	104,471	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,916	19
20	Radiology and X-Ray	2,061	20
21	Other Medical Services	2,976	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 113,424	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts - Vending	261	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 261	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,542,736	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	746,201	31
32	Health Care	2,297,606	32
33	General Administration	1,239,059	33
B. Capital Expense			
34	Ownership	394,575	34
C. Ancillary Expense			
35	Special Cost Centers	97,503	35
36	Provider Participation Fee	169,248	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,944,192	40
41	Income before Income Taxes (line 30 minus line 40)**	(401,456)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (401,456)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,820,337	44
45	Private Pay - Net Inpatient Revenue	758,994	45
46	Medicare - Net Inpatient Revenue	780,336	46
47	Other-(specify) HMO/Insurance	9,281	47
48	Other-(specify) VA/Charity	68,229	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,437,177	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 **SSC Hamilton Operating Company LLC dba Montebello E** # **0047340**

Report Period Beginning: **01/01/2017**

Ending: **12/31/2017**

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	980	1,127	\$ 39,646	\$ 35.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,892	13,702	393,832	28.74	3
4	Licensed Practical Nurses	6,396	6,605	166,063	25.14	4
5	CNAs & Orderlies	38,625	42,399	509,346	12.01	5
6	CNA Trainees					6
7	Licensed Therapist	9,426	10,100	410,378	40.63	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,155	2,274	33,596	14.77	9
10	Activity Assistants					10
11	Social Service Workers	1,941	2,077	44,623	21.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,981	2,069	44,344	21.43	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,085	2,320	101,048	43.56	20
21	Assistant Administrator					21
22	Other Administrative	3,970	4,154	99,557	23.97	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Medicare Coord	2,077	2,251	26,892	11.95	32
33	Other(specify)	1,813	2,086	29,928	14.35	33
34	TOTAL (lines 1 - 33)	84,341	91,164	\$ 1,899,253 *	\$ 20.83	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	\$ 231,534	1-3	35
36	Medical Director	10,356	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,820	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	3,292	11-3	44
45	Social Service Consultant	2,797	12-3	45
46	Other(specify) Administrative	11,681	10-3	46
47	Xray & Laboratory	19,355	39-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 285,835		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 73,069	10*3	50
51	Licensed Practical Nurses	143,074	10-3	51
52	Certified Nurse Assistants/Aides	88,619	10-3	52
53	TOTAL (lines 50 - 52)	\$ 304,762		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		
Jonni Bullington	Administrator	0	\$ 96,048	Workers' Compensation Insurance	\$ 72,359	IDPH License Fee	\$		
				Unemployment Compensation Insurance	16,801	Advertising: Employee Recruitment	30,647		
				FICA Taxes	138,244	Health Care Worker Background Check	6,447		
				Employee Health Insurance	91,869	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	946		
				Employee Life Insurance	1,272	Dues	10,323		
				Other Benefits	10,345	Other Licenses	2,780		
				Home Office Payroll Taxes	19,045	Fees, Subscriptions and Promos	232		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,048	TOTAL (agree to Schedule V, line 22, col.8)		\$ 65,683			
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	\$ 7,791	
							In-State Travel	14,469	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	5,177	
C. Professional Services							Home Office Allocation		13,047
Vendor/Payee	Type		Amount				Entertainment Expense ()		
Anderson Bloom	Admin Consultant		\$ 4,100				(agree to Sch. V, line 24, col. 8)		
Bradley Assoc	Admin Consultant		450				TOTAL		
Cass Information Systems			869				\$ 40,484		
Compsych	Employee Asst Progra		901						
Duane Morris LLP	Legal		297						
Engie Insight	Utility Management		74						
Equifax	Background		525						
James F Dennis Law Firm	Legal		777						
LexisNexis			64						
NRC Health	Survey Program		568						
ProbateFinder/ProTitle	Proeprty Search		538						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 9,163						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SSC Hamilton Operating Company LLC dba Montebello Health Care C # 0047340 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 \$9,875
- (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. \$ 33,344 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. \$ 169,248
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?
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