

		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.

I. IDPH License ID Number: 0052522

Facility Name: Brentwood Sub Acute HCC

Address: 5400 West 87th St Burbank 60459
Number City Zip Code

County: Cook

Telephone Number: 708 423-1200 Fax # 708 423-8405

HFS ID Number:

Date of Initial License for Current Owners: 01/012014

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Martha McDaniel Telephone Number: 832-467-6317
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Chris Stenger
(Title) Senior Vice President of Planning and Reimbursement

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number Brentwood Sub Acute HCC

0052522 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	<u>163</u>	Skilled (SNF)	<u>163</u>	<u>59,658</u>	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	<u>163</u>	TOTALS	<u>163</u>	<u>59,658</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,282</u>	<u>2,226</u>	<u>17,102</u>	<u>28,610</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,282</u>	<u>2,226</u>	<u>17,102</u>	<u>28,610</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.96%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 163 and days of care provided 10,413

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 **Brentwood Sub Acute HCC** # **0052522** 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		1,131	529,272	530,403		530,403	(205,420)	324,983			1
2	Food Purchase		4,688		4,688		4,688	205,082	209,770			2
3	Housekeeping		28,476	294,984	323,460		323,460		323,460			3
4	Laundry		15,337	177,773	193,110		193,110		193,110			4
5	Heat and Other Utilities			182,816	182,816		182,816	(5,770)	177,046			5
6	Maintenance	86,800	232,487	32,149	351,436		351,436	54,850	406,286			6
7	Other (specify):*			37,804	37,804		37,804		37,804			7
8	TOTAL General Services	86,800	282,119	1,254,798	1,623,717		1,623,717	48,742	1,672,459			8
	B. Health Care and Programs											
9	Medical Director			72,000	72,000		72,000		72,000			9
10	Nursing and Medical Records	3,299,715	474,046	149,345	3,923,106		3,923,106	601,655	4,524,761			10
10a	Therapy	1,795,457	296,755	84,121	2,176,333		2,176,333		2,176,333			10a
11	Activities	45,297	4,047	3,623	52,967		52,967		52,967			11
12	Social Services	96,818			96,818		96,818		96,818			12
13	CNA Training											13
14	Program Transportation			13,140	13,140		13,140		13,140			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,237,287	774,848	322,229	6,334,364		6,334,364	601,655	6,936,019			16
	C. General Administration											
17	Administrative	123,457			123,457		123,457	11,813	135,270			17
18	Directors Fees			366	366		366		366			18
19	Professional Services			79,022	79,022		79,022	(3,140)	75,882			19
20	Dues, Fees, Subscriptions & Promotions			49,986	49,986		49,986	404	50,390			20
21	Clerical & General Office Expenses	355,903	21,939	1,254,815	1,632,657		1,632,657	(1,630,514)	2,143			21
22	Employee Benefits & Payroll Taxes			1,108,116	1,108,116		1,108,116	75,830	1,183,946			22
23	Inservice Training & Education											23
24	Travel and Seminar			43,165	43,165		43,165	55,244	98,409			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			2,601,342	2,601,342		2,601,342	(2,325,578)	275,764			26
27	Other (specify):* Franchise Tax							300	300			27
28	TOTAL General Administration	479,360	21,939	5,136,812	5,638,111		5,638,111	(3,815,641)	1,822,470			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,803,447	1,078,906	6,713,839	13,596,192		13,596,192	(3,165,244)	10,430,948			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,154,311	1,154,311		1,154,311	(983,629)	170,682			30
31	Amortization of Pre-Op. & Org.			(17,221)	(17,221)		(17,221)		(17,221)			31
32	Interest			443,003	443,003		443,003	56,570	499,573			32
33	Real Estate Taxes			972,726	972,726		972,726	5,044	977,770			33
34	Rent-Facility & Grounds			4,620	4,620		4,620		4,620			34
35	Rent-Equipment & Vehicles			63	63		63		63			35
36	Other (specify):*							72,374	72,374			36
37	TOTAL Ownership			2,557,502	2,557,502		2,557,502	(849,641)	1,707,861			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		584,957	308,229	893,186		893,186		893,186			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,551	200,551		200,551		200,551			42
43	Other (specify):* Laboratory		3,974		3,974		3,974		3,974			43
44	TOTAL Special Cost Centers		588,931	508,780	1,097,711		1,097,711		1,097,711			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,803,447	1,667,837	9,780,121	17,251,405		17,251,405	(4,014,885)	13,236,520			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(257)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,847)	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	(81)	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	(58)	21		18
19	Entertainment	(1,452)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(71,762)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,089,724)	21		24
25	Fund Raising, Advertising and Promotional	26,801	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,230)	20		28
29	Other-Attach Schedule	(4,376,139)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,519,749)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)	1,013,566		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,013,566		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (4,506,183)		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Depreciation Adj (Remove Cap Lease Depr)	\$ (983,629)	30	1
2	Reclass Franchise Tax	(300)	33	2
3	Reclass Franchise Tax	300	27	3
4	Real Estate Accrual Adjustment	5,344	33	4
5	Back Office Service Fee	(576,054)	21	5
6	Professional Liability Insurance	(2,330,502)	26	6
7	Reclass Raw Food	(205,420)	1	7
8	Reclass Raw Food	205,420	2	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	(3,884,841)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brentwood Sub Acute HCC # 0052522 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	(205,420)	0	0	0	0	0	0	0	0	0	0	(205,420)	1
2	Food Purchase	205,082	0	0	0	0	0	0	0	0	0	0	205,082	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	(5,847)	77	0	0	0	0	0	0	0	0	0	(5,770)	5
6	Maintenance	0	54,850	0	0	0	0	0	0	0	0	0	54,850	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,185)	54,927	0	0	0	0	0	0	0	0	0	48,742	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	601,655	0	0	0	0	0	0	0	0	0	601,655	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	601,655	0	0	0	0	0	0	0	0	0	601,655	16
	C. General Administration													
17	Administrative	0	11,813	0	0	0	0	0	0	0	0	0	11,813	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(71,762)	68,622	0	0	0	0	0	0	0	0	0	(3,140)	19
20	Fees, Subscriptions & Promotions	(1,230)	1,634	0	0	0	0	0	0	0	0	0	404	20
21	Clerical & General Office Expenses	(1,639,035)	8,521	0	0	0	0	0	0	0	0	0	(1,630,514)	21
22	Employee Benefits & Payroll Taxes	0	75,830	0	0	0	0	0	0	0	0	0	75,830	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,452)	56,696	0	0	0	0	0	0	0	0	0	55,244	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,330,502)	4,924	0	0	0	0	0	0	0	0	0	(2,325,578)	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	TOTAL General Administration	(4,043,681)	228,040	0	0	0	0	0	0	0	0	0	(3,815,641)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(4,049,866)	884,622	0	0	0	0	0	0	0	0	0	(3,165,244)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brentwood Sub Acute HCC # 0052522 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	(983,629)	0	0	0	0	0	0	0	0	0	0	(983,629)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	56,570	0	0	0	0	0	0	0	0	0	56,570	32
33	Real Estate Taxes	5,044	0	0	0	0	0	0	0	0	0	0	5,044	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	72,374	0	0	0	0	0	0	0	0	0	72,374	36
37	TOTAL Ownership	(978,585)	128,944	0	0	0	0	0	0	0	0	0	(849,641)	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)	(5,028,451)	1,013,566	0	0	0	0	0	0	0	0	0	(4,014,885)	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
SWC Illinois Holdco, LLC	100		Burbank	SWC Equity Holdings LLC		Holding Company
				SSC Equity Holdings LLC		Holding Company
				SSC Administratives Services, LLC		Back Office Services
				SSC Consulting Services LLC		Consulting Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	SSC Equity Holdings LLC	100.00%	\$ 77	\$ 77	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	54,850	54,850	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	68,622	68,622	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	1,634	1,634	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	601,655	601,655	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	8,521	8,521	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	56,696	56,696	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	4,924	4,924	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	72,374	72,374	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	11,813	11,813	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%	56,570	56,570	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	75,830	75,830	13
14	Total			\$			\$ 1,013,566	\$ * 1,013,566	14

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

Facility Name & ID Number

Brentwood Sub Acute HCC

0052522

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 Heath 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

Brentwood Sub Acute HCC

0052522

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	Austll				11
12			Brian Center Health & Rehab Canton	Canton				12
13			Northeast Atlanta Healty & Rehab	Atlanta				13
14			Brighton Place West	Topeka				14
15			Indian Creek Healht Care Center	Overland Park				15
16			SE Massachusetts Health & Rehab	New Bedford				16
17			Methuen Health & Rehab Center	Methuen				17
18			Patuxent River Health & Rehab Center	Laurel				18
19			Arcola Heatlh & Rehab Center	Silver Spring				19
20			Glen Burnie Health & Rehab Center	Glen Burnie				20
21			Overlea Health & Rehab Center	Baltimore				21
22			Bethesda Health & Rehab Center	Bethesda				22
23			Summit Park Health & Rehab Center	Catonsville				23
24			North Arundel Health & Rehab Center	Glen Burnie				24
25			Bel Air Health & Rehab Center	Bel Air				25
26			Forest Hill Health & Rehab Center	Forest Hill				26
27			Heritage Harbour Health & Rehab Center	Annapolis				27
28			Cambridge East	Madison Heights				28
29			Cambridge North	Clawson				29
30			Cambridge South	Beverly Hills				30

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STATE OF ILLINOIS

Page 6-Supplemental (3)

Facility Name & ID Number Brentwood Sub Acute HCC # 0052522 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 & 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 Brentwood Sub Acute HCC # 0052522 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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STATE OF ILLINOIS

Page 6-Supplemental (4)

Facility Name & ID Number Brentwood Sub Acute HCC # 0052522 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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STATE OF ILLINOIS

Facility Name & ID Number Brentwood Sub Acute HCC # 0052522 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

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 Brentwood Sub Acute HCC # 0052522 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

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

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.)

FACILITY NAME Brentwood Sub Acute HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052522

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832 467-6317 FAX #: 832 467-6984

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.

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.)

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: 43,476 **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

Facility Name & ID Number Brentwood Sub Acute HCC

0052522

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	163		2014		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Heat Exchanger RTU #18			2014	3,568	1,189	3	1,189		3,568	9
10	Water Heater 2nd Floor			2014	12,550	4,303	3	4,303		12,550	10
11	Polycom Phone			2014	521	169	3	169		521	11
12	Recirculation Pump on Boiler			2014	1,835	629	3	629		1,835	12
13	2: Vestibule Heaters			2014	4,827	1,704	3	1,704		4,827	13
14	Door Controller			2014	972	343	3	343		972	14
15	Water Heater - Laundry			2014	12,550	4,706	2.67	4,706		12,550	15
16	Damper Motor			2014	2,803	1,121	2.5	1,121		2,804	16
17	Chain Link Fence			2014	12,208	5,052	2.5	5,052		12,208	17
18	2 Metal Doors Installed			2014	4,890	2,096	2.33	2,096		4,890	18
19	Backflow Preventers			2014	5,824	2,184	2.67	2,184		5,824	19
20	Asphalt - Sawcut, Remove & Patch			2014	3,498	1,166	2.25	1,166		3,498	20
21	Motor, Fan for A/C Unit			2014	4,667	400	11.67	400		900	21
22	Pipes and Valves			2014	6,107	611	10	611		1,374	22
23	Hollow Metal Door w/Window			2014	1,553	621	2.5	621		1,553	23
24	Chiller & Unit for Gym			2014	5,013	430	11.67	430		967	24
25	Replaced Freezer Door			2014	4,940	426	11.58	426		924	25
26	Replaced AC Control Kit			2014	2,440	244	10	244		508	26
27											27
28	F1000-08 Wall Cabinet Fan Coil			2015	4,245	372	11.4	372		744	28
29	Install 3 Mortise Locks			2015	3,095	1,326	2.33	1,326		3,095	29
30	Install Pump			2015	4,571	457	10	457		914	30
31	Installed Inducer Motor			2015	1,764	154	11.4	154		309	31
32	Commercial Disposal			2015	2,055	411	5	411		822	32
33	Pleat Valance			2015	1,104	221	5	221		423	33
34	Manifold Replacement			2015	4,016	354	11.33	354		679	34
35	APC Smart Ups			2015	1,139	114	10	114		218	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 Brentwood Sub Acute HCC

0052522

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	APC Smart Ups	2015	\$ 680	\$ 68	10	\$ 68		\$ 130	37
38	Phone System	2015	234	23	10	23		45	38
39	CMBS Roof Replacement	2015	192,000	19,200	10	19,200		35,200	39
40	Analog Gateway	2015	4,472	447	10	447		820	40
41	Vacuum Compressor	2015	18,608	1,642	11.3	1,642		3,147	41
42	Booster Heather Kit	2015	2,200	220	10	220		385	42
43	Replaced Dryer in Cooler	2015	2,061	185	11.17	185		323	43
44	A/C Unit	2015	8,622	862	10	862		1,437	44
45	Landscaping Survey	2015	10,582	1,058	10	1,058		1,764	45
46	Landscaping Survey	2015	2,324	232	10	232		387	46
47	Installed Vacuum Compressr	2015	9,985	901	11	901		1,501	47
48	CMBS Roof Replacement	2015	195,840	19,584	10	19,584		31,008	48
49	Water Heater	2015	1,314	131	10	131		208	49
50	Asphalt Pavement	2015	27,625	3,453	8	3,453		5,467	50
51	CMBS Installed TPC Duct Work	2015	40,597	4,060	10	4,060		6,428	51
52	CMS Piping	2015	18,944	1,722	11	1,722		2,727	52
53	Compressor - Rooftop Chiller	2015	18,032	1,803	10	1,803		2,855	53
54	Wooden Door	2015	1,618	146	11	146		243	54
55	CMPS Asphalt Pavement	2015	27,625	3,453	8	3,453		4,892	55
56	CMBS Installed TPC Duct Work	2015	(40,597)	(4,060)	10	(4,060)		(5,751)	56
57	Replaced Fire Rated Door	2015	3,017	281	10.75	281		374	57
58	AASTRA: 68671 I Phone	2015	7,234	723	10	723		1,025	58
59	Water Control Valve	2015	29,002	2,637	11	2,637		4,175	59
60	Chiller and Air Handler	2015	2,061	773	2.67	773		2,061	60
61	Replaced Circulating Pump	2015	2,863	286	10	286		310	61
62	Pressure Control Tansducer	2015	2,792	279	10	279		302	62
63	Circulating Pump	2015	4,588	459	10	459		880	63
64	Chiller Pump Replace	2015	6,643	608	11	608		913	64
65	Valve Seal Kit	2015	1,805	722	2.5	722		1,805	65
66	Vacuum Vane	2015	2,837	1,001	2.83	1,001		2,837	66
67	Kitchen Hood Motor	2015	2,360	236	10	236		433	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 720,723	\$ 93,938		\$ 93,938		\$ 187,808	70

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

Facility Name & ID Number Brentwood Sub Acute HCC

0052522

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	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		\$ 720,723	\$ 93,938		\$ 93,938	\$	\$ 187,808	1
2 CMBS PVC Fencing	2016	15,300	1,913	8	1,913		1,913	2
3 Wood Door Replacement	2016	2,678	314	10.6	314		314	3
4 Electric Conduit	2016	3,163	257	10.25	257		257	4
5 CMBS Landscaping Survey	2016	3,500	233	10	233		233	5
6 Sttel Door Prepped fro Mortise	2016	2,980	220	10.25	220		220	6
7 Hot Water Loop for Boiler	2016	4,209	246	10	246		246	7
8 Boiler Instatllation	2016	90,272	5,266	10	5,266		5,266	8
9 Landscaping Artic Fire Dogwoo	2016	12,878	546	9.8	546		546	9
10 Chilled and Hot Water Lop	2016	5,758	149	5	149		149	10
11 Fire Alarm - Backflow Parts	2016	2,938	76	9.6	76		76	11
12 Mixing Valve Cartridge Assembly	2016	1,738	159	10	159		159	12
13 2 Motors for HVAC	2016	4,170	626	10	626		626	13
14 Circulating Pump	2016	2,030	271	10	271		271	14
15 Door Closers	2016	1,509	145	10.4	145		145	15
16 Motor for Garbage Disposal	2016	1,468	269	5	269		269	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)		\$ 875,314	\$ 104,628		\$ 104,628	\$	\$ 198,498	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 184,658	\$ 52,564	\$ 52,564	\$		\$ 52,564	71
72	Current Year Purchases	96,120	13,490	13,490			13,490	72
73	Fully Depreciated Assets	(1)						73
74								74
75	TOTALS	\$ 280,777	\$ 66,054	\$ 66,054	\$		\$ 66,054	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	2	
	Reference	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)	\$ 1,156,091	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,682	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,682	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)	\$ 264,552	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:
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:	1962	163	01/01/2014	\$ 4,620	3	5	3
4	Additions	1985						4
5		2002						5
6								6
7	TOTAL		163		\$ 4,620			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease 12.
-

9. Option to Buy: ☐ YES ☒ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)											
		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-03	11523	hrs	\$ 434,900		\$ 22,782	\$	11,523	\$ 457,682	1
2	Licensed Speech and Language Development Therapist	10a-03	2004	hrs	85,613		3,191		2,004	88,804	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	21260	hrs	762,422		25,790		21,260	788,212	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				584,967		584,967	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				\$ 1,282,935		\$ 51,763	\$ 584,967	34,787	\$ 1,919,665	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	\$ 600	\$	1
2	Cash-Patient Deposits	59,738		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,939,951		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,467		6
7	Other Prepaid Expenses	4,762		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,006,518	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,464		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	875,315		15
16	Equipment, at Historical Cost	280,777		16
17	Accumulated Depreciation (book methods)	(834,031)		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):	6,132		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 336,657	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,343,175	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 440,842	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,264,322		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,053,163		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	454,415		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,212,742	\$	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>	9,671,056		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,671,056	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,883,798	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (27,792,028)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (14,908,230)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,835,157)	1
2	Restatements (describe):	(17,242,840)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (22,077,997)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,714,031)	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)	\$ (5,714,031)	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)	\$ (27,792,028)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Brentwood Sub Acute HCC

0052522

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 19,379,969	1
2	Discounts and Allowances for all Levels	(18,123,808)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,256,161	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,445,406	6
7	Oxygen	100	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 9,445,506	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	(64)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	813,388	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,194	19
20	Radiology and X-Ray	3,801	20
21	Other Medical Services	495	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 831,814	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	Miscellaneous Receipts	3,893	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,893	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,537,374	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,623,717	31
32	Health Care	6,334,364	32
33	General Administration	5,638,111	33
	B. Capital Expense		
34	Ownership	2,557,502	34
	C. Ancillary Expense		
35	Special Cost Centers	893,186	35
36	Provider Participation Fee	200,551	36
	D. Other Expenses (specify):		
37		3,974	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,251,405	40
41	Income before Income Taxes (line 30 minus line 40)**	(5,714,031)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,714,031)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 803,522	44
45	Private Pay - Net Inpatient Revenue	538,264	45
46	Medicare - Net Inpatient Revenue	575,017	46
47	Other-(specify) <u>HMO/Insurance</u>	(460,149)	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	(200,493)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,256,161	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.

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	1,954	3,413	\$ 164,688	\$ 48.25	1
2	Assistant Director of Nursing	772	919	32,998	35.91	2
3	Registered Nurses	15,143	16,596	569,883	34.34	3
4	Licensed Practical Nurses	47,877	51,992	1,440,255	27.70	4
5	CNAs & Orderlies	61,584	74,283	1,038,665	13.98	5
6	CNA Trainees					6
7	Licensed Therapist	51,862	54,426	1,795,457	32.99	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,164	1,398	21,307	15.24	9
10	Activity Assistants	2,379	2,498	23,990	9.60	10
11	Social Service Workers	4,126	4,473	96,818	21.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,768	4,181	86,800	20.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,968	2,108	133,373	63.27	20
21	Assistant Administrator					21
22	Other Administrative	10,965	11,867	301,198	25.38	22
23	Office Manager					23
24	Clerical	3,900	4,188	44,789	10.69	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	2,008	2,250	53,226	23.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,470	234,592	\$ 5,803,447 *	\$ 24.74	34

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		\$ 320,666	1-3	35
36	Medical Director		72,000	9-3	36
37	Medical Records Consultant		2,000	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		8,368	10-3	39
40	Physical Therapy Consultant		25,790	10a-3	40
41	Occupational Therapy Consultant		22,782	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		3,191	10a-3	43
44	Activity Consultant		2,016	11-3	44
45	Social Service Consultant				45
46	Other(specify) <u>Admin</u>		118,543	10-3	46
47	<u>XRay & Laboratory</u>		186,323	39-3	47
48	<u>Dentist/Physician/Psychiatrist</u>		109,500	39-3	48
49	TOTAL (lines 35 - 48)		\$ 871,179		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Brentwood Sub Acute HCC

#

0052522

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description			Description			Amount	
David Zaruba		Administrator	0	\$ 62,010	Workers' Compensation Insurance		\$	IDPH License Fee		\$		
Ayodeji Adegoge		Administrator	0	61,447	Unemployment Compensation Insurance			Advertising: Employee Recruitment			7,342	
					FICA Taxes			Health Care Worker Background Check			15,409	
					Employee Health Insurance			(Indicate # of checks performed)				
					Employee Meals			Patient Background Checks				
					Illinois Municipal Retirement Fund (IMRF)*			Publications and Manuals			820	
					Life Insurance			Professional Dues			17,913	
					Other Benefits			Other Licenses			7,272	
					Home Office Payroll Taxes			Fees, Subscriptions and Promos			1,634	
TOTAL (agree to Schedule V, line 17, col. 1)												
(List each licensed administrator separately.)				\$ 123,457								
B. Administrative - Other												
Description			Amount	Description			Amount	Less: Public Relations Expense			()	
			\$					Non-allowable advertising			()	
								Yellow page advertising			()	
				TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,183,946	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 50,390	
TOTAL (agree to Schedule V, line 17, col. 3)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)												
C. Professional Services												
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description			Amount	
Burgeon Legal Group		Legal	\$ 68,419				\$	Out-of-State Travel		\$	3,310	
Cass Information Systems		Waste Expense Mgmt	1,488									
Compsych		Employee Services	1,107									
Duane Morris LLP		Legal	197					In-State Travel			29,384	
Ecova Inc		Utility Management	119									
EK Life Safety Consult		Life Safety	750									
Equifax		Background	628									
LexisNexis		Data Research Mgmt	170					Seminar Expense			9,018	
Mary Hupke BSMT		Lab Mgmt	1,125									
National Research		Survey Tracking	1,152					Home Office Allocation			56,696	
Ogletree Deakins Nash Smoak		Legal	2,958									
Probate Finder/Protittle USA		Title Search	909					Entertainment Expense		()		
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL				(agree to Sch. V, line 24, col. 8)			
(For legal fee disclosure, see page 39 of instructions)				\$ 79,022					TOTAL			
									\$ 98,408			

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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?
If YES, give association name and amount. Illinois Health Care Association \$17,883
Yes

(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?
What was the average life used for new equipment added during this period? Yes

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,721 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?
If YES, give effective date of lease. No

(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.
This amount is to be recorded on line 42 of Schedule V. \$ 200,551

(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 benefit 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?
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
No

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: BDO Seidman LLC (Corporate Level) Yes

(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