

		FOR BHF USE					

LL1

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: 0047340

Facility Name: Montebello Healthcare Center

Address: 1599 Keokuk Street Hamilton 62341
Number City Zip Code

County: Hancock

Telephone Number: 271 847 3931 Fax # 217 847 2067

HFS ID Number:

Date of Initial License for Current Owners: 10/06/2005

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 Montebello Healthcare Center

0047340 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>139</u>	Skilled (SNF)	<u>139</u>	<u>50,874</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>139</u>	TOTALS	<u>139</u>	<u>50,874</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>15,358</u>	<u>3,870</u>	<u>3,217</u>	<u>22,445</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>15,358</u>	<u>3,870</u>	<u>3,217</u>	<u>22,445</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.12%

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 139 and days of care provided 2,661

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 **Montebello Healthcare Center** # **0047340** 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	10,336	930	304,589	315,855		315,855	(84,393)	231,462			1
2	Food Purchase		104		104		104	84,393	84,497			2
3	Housekeeping		654	98,265	98,919		98,919		98,919			3
4	Laundry		6,296	65,484	71,780		71,780		71,780			4
5	Heat and Other Utilities			101,665	101,665		101,665	(3,926)	97,739			5
6	Maintenance	33,408	60,155	11,687	105,250		105,250	12,635	117,885			6
7	Other (specify):*			7,429	7,429		7,429		7,429			7
8	TOTAL General Services	43,744	68,139	589,119	701,002		701,002	8,709	709,711			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,160,005	94,798	152,754	1,407,557		1,407,557	138,595	1,546,152			10
10a	Therapy	294,908	17,037	6,700	318,645		318,645		318,645			10a
11	Activities	39,728	5,481	4,973	50,182		50,182		50,182			11
12	Social Services	44,522		2,737	47,259		47,259		47,259			12
13	CNA Training											13
14	Program Transportation	29,314	4,847	29	34,190		34,190		34,190			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,568,477	122,163	174,393	1,865,033		1,865,033	138,595	2,003,628			16
	C. General Administration											
17	Administrative	82,816			82,816		82,816	2,721	85,537			17
18	Directors Fees			381	381		381		381			18
19	Professional Services			16,745	16,745		16,745	4,224	20,969			19
20	Dues, Fees, Subscriptions & Promotions			39,135	39,135		39,135	(3,748)	35,387			20
21	Clerical & General Office Expenses	63,207	15,503	331,186	409,896		409,896	(279,888)	130,008			21
22	Employee Benefits & Payroll Taxes			256,180	256,180		256,180	17,468	273,648			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,295	12,295		12,295	13,060	25,355			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			22,666	22,666		22,666	(4,561)	18,105			26
27	Other (specify):* Franchise Tax							300	300			27
28	TOTAL General Administration	146,023	15,503	678,588	840,114		840,114	(250,424)	589,690			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,758,244	205,805	1,442,100	3,406,149		3,406,149	(103,120)	3,303,029			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			116,337	116,337		116,337	(21,267)	95,070			30
31	Amortization of Pre-Op. & Org.			9,239	9,239		9,239		9,239			31
32	Interest			(32,317)	(32,317)		(32,317)	13,031	(19,286)			32
33	Real Estate Taxes			74,217	74,217		74,217	(5,930)	68,287			33
34	Rent-Facility & Grounds			81,969	81,969		81,969		81,969			34
35	Rent-Equipment & Vehicles			7,388	7,388		7,388		7,388			35
36	Other (specify):*							16,672	16,672			36
37	TOTAL Ownership			256,833	256,833		256,833	2,506	259,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,481	10,696	71,177		71,177		71,177			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,589	195,589		195,589		195,589			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		60,481	206,285	266,766		266,766		266,766			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,758,244	266,286	1,905,218	3,929,748		3,929,748	(100,614)	3,829,134			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				4
5	Telephone, TV & Radio in Resident Rooms	(3,944)	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				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	(5)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,584)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,754)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,124)	20		28
29	Other-Attach Schedule	(233,684)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (334,095)		\$	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)	233,481		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 233,481		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (100,614)		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)	\$ (21,267)	30	1
2	Reclass Franchise Tax	(300)	33	2
3	Reclass Franchise Tax	300	27	3
4	Real Estate Accrual Adjustment	(5,630)	33	4
5	Back Office Service Fee	(201,092)	21	5
6	Professional Liability Insurance	(5,695)	26	6
7	Reclass Raw Food Exense	(84,393)	1	7
8	Reclass Raw Food Exense	84,393	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(233,684)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center# 0047340

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	(84,393)	0	0	0	0	0	0	0	0	0	0	(84,393)	1
2	Food Purchase	84,393	0	0	0	0	0	0	0	0	0	0	84,393	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,944)	18	0	0	0	0	0	0	0	0	0	(3,926)	5
6	Maintenance	0	12,635	0	0	0	0	0	0	0	0	0	12,635	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,944)	12,653	0	0	0	0	0	0	0	0	0	8,709	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	138,595	0	0	0	0	0	0	0	0	0	138,595	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	138,595	0	0	0	0	0	0	0	0	0	138,595	16
	C. General Administration													
17	Administrative	0	2,721	0	0	0	0	0	0	0	0	0	2,721	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,584)	15,808	0	0	0	0	0	0	0	0	0	4,224	19
20	Fees, Subscriptions & Promotions	(4,124)	376	0	0	0	0	0	0	0	0	0	(3,748)	20
21	Clerical & General Office Expenses	(281,851)	1,963	0	0	0	0	0	0	0	0	0	(279,888)	21
22	Employee Benefits & Payroll Taxes	0	17,468	0	0	0	0	0	0	0	0	0	17,468	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	13,060	0	0	0	0	0	0	0	0	0	13,060	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(5,695)	1,134	0	0	0	0	0	0	0	0	0	(4,561)	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	TOTAL General Administration	(302,954)	52,530	0	0	0	0	0	0	0	0	0	(250,424)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(306,898)	203,778	0	0	0	0	0	0	0	0	0	(103,120)	29

Summary B

12/31/2016

[illegible]

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 Vernont	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:	
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%	\$ 18	\$ 18	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	12,635	12,635	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	15,808	15,808	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	376	376	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	138,595	138,595	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	1,963	1,963	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	13,060	13,060	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	1,134	1,134	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	16,672	16,672	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	2,721	2,721	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%	13,031	13,031	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	17,468	17,468	13
14	Total			\$			\$ 233,481	\$ * 233,481	14

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

Facility Name & ID Number

Montebello Healthcare Center

0047340

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

Montebello Healthcare Center

0047340

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 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

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Facility Name & ID Number Montebello Healthcare Center # 0047340 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

Facility Name & ID Number Montebello Healthcare Center # 0047340 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	<u>SSC Equity Holding Company LLC</u>	<u>100</u>	<u>Bastrop Nursing Center</u>	<u>Bastrop</u>				1
2			<u>Care Inn of La Grange</u>	<u>La Grange</u>				2
3			<u>Kountze Nursing Center</u>	<u>Kountze</u>				3
4			<u>Retama Manor Nursing Center San Antonio No</u>	<u>San Antonio</u>				4
5			<u>Retama Manor Nursing Center San Antonio We</u>	<u>San Antonio</u>				5
6			<u>Retama Manor Nursing Center Alice</u>	<u>Alice</u>				6
7			<u>Retama Manor Nursing Center Edinburg</u>	<u>Edinburg</u>				7
8			<u>Retama Manor Nursing Center Harlingen</u>	<u>Harlingen</u>				8
9			<u>Retama Manor Nursing Center Jourdanton</u>	<u>Jourdanton</u>				9
10			<u>Retama Manor Nursing Center Laredo South</u>	<u>Laredo</u>				10
11			<u>Retama Manor Nursing Center Laredo West</u>	<u>Laredo</u>				11
12			<u>Retama Manor Nursing Center McAllen</u>	<u>McAllen</u>				12
13			<u>Retama Manor Nursing Center Pleasanton Nort</u>	<u>Pleasanton</u>				13
14			<u>Retama Manor Nursing Center Pleasanton Sout</u>	<u>Pleasanton</u>				14
15			<u>Retama Manor Nursing Center Rio Grande City</u>	<u>Rio Grande City</u>				15
16			<u>Retama Manor Nursing Center Robstown</u>	<u>Robstown</u>				16
17			<u>Retama Manor Nursing Center Weslaco</u>	<u>Weslaco</u>				17
18			<u>Weatherford health Care Center</u>	<u>Weatherford</u>				18
19			<u>Peach Tree Place</u>	<u>Weatherford</u>				19
20			<u>Retama Manor Nursing Center Raymondville</u>	<u>Raymondville</u>				20
21			<u>Memorial City Health and Rehab</u>	<u>Houston</u>				21
22			<u>Jacinto City Healthcare Center</u>	<u>Houston</u>				22
23			<u>Spring Branch Healthcare Center</u>	<u>Houston</u>				23
24			<u>Retama Manor Nursing Center Corpus Christi</u>	<u>Corpus Christi</u>				24
25			<u>Downtown Health & Rehab</u>	<u>Fort Worth</u>				25
26			<u>Lakeshore Village Healthcare Center</u>	<u>Waco</u>				26
27			<u>Deer Creek of Wimberley</u>	<u>Wimberley</u>				27
28			<u>La Paloma Nursing Center</u>	<u>San Diego</u>				28
29			<u>Pine Arbor</u>	<u>Silsbee</u>				29
30			<u>Las Palmas Healthcare Center</u>	<u>McAllen</u>				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

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Facility Name & ID Number	Montebello Healthcare Center	#	0047340	Report Period Beginning:	01/01/2016	Ending:	12/31/2016
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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 Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization SSC Equity Holdings LLC
Street Address 5300 W Sam Houston Pkwy N Ste 100
City / State / Zip Code Houston, TX 77041
Phone Number (832-467-6000
Fax Number (832-467-6984

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities				\$	\$		18	1
2	6	Repair and Maintenance							12,635	2
3	19	Professional Services							15,808	3
4	20	Fee, Subscriptions and Promos							376	4
5	10	Nursing & Medical Records							138,595	5
6	21	Clerical & Gen Office Exp							1,963	6
7	24	Travel & Seminar							13,060	7
8	26	Insurance							1,134	8
9	36	Drpreiation							16,672	9
10	17	Communications							2,721	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense							13,031	12
13	22	Payroll Taxes							17,468	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					\$	\$		233,481	25

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.)

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 2015 report.			\$	65,970	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.)			\$	68,287	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,317	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	72,717	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.			\$	75,034	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	61,568	8	
		2012	62,762	9	
		2013	62,828	10	
		2014	67,047	11	
		2015	68,287	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montebello Healthcare Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0047340

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 11-29-999-119	Lot B Sub (Ex 2A Se Corner &	\$ 68,287.00	\$ 68,287.00
2.	377 x 145 SW Corner) NE	\$	\$
3.	Montebello 5-8 12-29B 11-538	\$	\$
4.	12-29-255-011 Keokuk Street	\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 68,287.00	\$ 68,287.00

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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	122	11.5	122		1,500	10
11	Repair Damaged Phone System			2005	1,576		10			1,576	11
12	Watermain Repair			2005	8,682	713	11.5	713		8,682	12
13	Retaining Wall - Partial Payment			2005	6,359	522	11.5	522		6,359	13
14	Fire Alarm Control Panel			2005	2,404		10			2,404	14
15	Construct Walkway Cover			2005	5,022	412	11.5	412		5,022	15
16	Leveled Ground around Stairway			2005	525	43	11.5	43		525	16
17	Fire Alarm System			2005	1,824		10			1,824	17
18	Install New Handrails			2005	415	34	11.5	34		415	18
19	Fire Alarm Control Panel			2005	872		10			872	19
20	Drywall Repairs - Water Break			2005	3,975	326	11.5	326		3,975	20
21	16: Toilet and Shower Floors			2005	10,166	847	11.3	847		10,166	21
22	Front Entry Concrete			2005	7,081	590	11.3	590		7,081	22
23	6: Smoke Detectors			2005	1,480		10			1,480	23
24	Relays for Emergency Lights			2005	2,776	231	11.3	231		2,776	24
25											25
26	119 Gallon Electric Water Heater			2006	4,362	36	10	36		4,362	26
27	Use Tax: Water Heater			2006	268	2	10	2		268	27
28	Install Water Heater			2006	659	5	10	5		659	28
29	Install Electrical Water Heater			2006	384	3	10	3		384	29
30	42' Sidewalk - Outside Patio			2006	1,820	163	10.175	163		1,820	30
31	Sprinkler			2006	2,296	205	10.175	205		2,296	31
32	Repair Sprinkler System			2006	6,893	627	10	627		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

Facility Name & ID Number Montebello Healthcare Center

0047340

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	
37 Deposit - Vinyl Floor	2007	\$ 1,928	\$ 189	9.25	\$ 189	\$	\$ 1,928	37
38 Vinyl Flooring	2007	2,153	215	9.08	215		2,153	38
39 Replace AC Compressor - Laundry	2007	1,663	166	9.08	166		1,663	39
40 Sprikler System Install	2007	1,744	173	9.16	173		1,744	40
41 Vinyl Flooring 2 Shower/Bathroom	2007	475	48	9	48		475	41
42								42
43								43
44 Backflow Devices - Sprinkler System	2008	21,646	2,205	9	2,205		21,646	44
45 Generator Water Pump	2008	4,412	467	8.58	467		4,412	45
46 Foundation Upgrade	2008	5,340	570	8.5	570		5,340	46
47 Sealed 3 Cracks Below Windows	2008	1,400	147	8.66	147		1,400	47
48 Water Abatement & Concrete Work	2008	2,670	288	8.41	288		2,670	48
49 Fire Alarm Maintenance	2008	3,191	351	8.25	351		3,191	49
50 Genset Wiring	2008	1,903	211	8.25	211		1,903	50
51 Generatro Remote Annunicator	2008	2,349	261	8.25	261		2,349	51
52 Dry System Accelerator	2008	8,020	882	8.25	882		8,020	52
53 Water Abatement & Concrete Work	2008	2,670	294	8.25	294		2,670	53
54								54
55								55
56 Wanderguard Monitor	2009	880	109	7.3	109		880	56
57 Concrete Sidewalk	2009	3,190	408	7.08	408		3,190	57
58 Anti Scald Mixing Valve	2009	1,074	134	7.25	134		1,074	58
59								59
60 Basement Door Locks	2010	2,263	296	6.92	296		2,263	60
61 Fire Alarm/Air Handler Connection	2010	5,363	621	7.83	621		5,363	61
62 Wanderguard System Credit	2010	(880)	(118)	6.75	(118)		(880)	62
63 Recepticles in 20 Rooms	2010	6,800	923	6.67	923		6,800	63
64 Intumescent Firestop	2010	18,880	2,596	6.58	2,596		18,880	64
65 5 Ton Central Air Conditioner	2010	4,580	654	6.34	654		4,580	65
66 Replaced Roof Membrane	2010	4,800	723	6	723		4,800	66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 207,409	\$ 17,694		\$ 17,694	\$	\$ 207,411	70

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

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 207,409	\$ 17,694		\$ 17,694	\$	\$ 207,411	1
2	Fire Alarm / Air Handler	2011	348	48		48		348	2
3	Install 2 Roof Top Units	2011	15,694	2,770		2,770		15,694	3
4	20 Wood Blinds	2011	2,964	296		296		2,964	4
5	17 Room Signs	2011	627	63		63		627	5
6	Shirred Valances and Rods	2011	2,912	340		340		2,912	6
7	Replace Tile & Vinyl flooring, walls, plumbing, & paint in 15 resid	2011	138,295	25,144		25,144		138,295	7
8	Replace electrical wiring and crown molding	2011	8,467	1,539		1,539		8,467	8
9									9
10	2 3 Ton Min Split Systems	2012	13,456	1,570		1,570		13,456	10
11	Commercial Disposal	2012	1,042	212		212		1,042	11
12									12
13	Stair Rail Panels	2013	1,991	478		478		1,991	13
14	Electrical for New Range	2013	1,285	343		343		1,285	14
15	NW Wing RTU Evaporator Coil	2013	2,986	874		874		2,986	15
16	Walk InCooler Compressor	2013	1,193	349		349		1,193	16
17	Nortstar Phone System	2013	15,745	4,723		4,723		15,745	17
18	A/C Blower Motor	2013	959	295		295		959	18
19									19
20	Polycom Phones	2014	521	169		169		521	20
21									21
22	CMBS Parking Curbs and Signs	2015	4,330	1,624		1,624		4,330	22
23	CMBS Strobe Fire Alarm Device	2015	2,000	200		200		450	23
24	CMBS Toilet Rooms	2015	1,400	120		120		270	24
25	CMBS Windows and Frame Replace	2015	1,320	113		113		255	25
26	Electrical Conduit	2015	2,064	166		166		499	26
27	50 ESA36-5, 3 Phase U	2015	6,418	1,283		1,283		2,353	27
28	Fire Panel	2015	2,387	239		239		358	28
29									29
30	Mounting Gasket for Commercial Disposal	2016	30	4		4		4	30
31	Commercial Disposal	2016	1,079	162		162		162	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 436,922	\$ 60,818		\$ 60,818	\$	\$ 424,577	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	\$203,573	\$28,990	\$28,990	\$		\$186,632	71
72	Current Year Purchases	75,444	5,262	5,262			5,262	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$279,017	\$34,252	\$34,252	\$		\$191,894	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)	\$715,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$95,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$95,070	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)	\$616,471	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number	Montebello Healthcare Center
--------------------------------------	-------------------------------------

0047340

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	139	10/16/2013	\$ 81,969	12		3
4	Additions							4
5								5
6								6
7	TOTAL		139		\$ 81,969			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 .

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?

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	Resident Transportation	2011 Ford E 350	\$ #####	\$ 7,388	17
18					18
19					19
20					20
21	TOTAL		\$ #####	\$ 7,388	21

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. /2017 \$ 1,136,460

13.	<u>2018</u>	\$ <u>1,136,460</u>
-----	-------------	---------------------

14. 2019 \$ 1,136,460

*** 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		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	1189 hrs	\$ 54,698		\$	\$	1,189	\$ 54,698	1
2	Licensed Speech and Language Development Therapist	10a-03	259 hrs	12,644				259	12,644	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	5573 hrs	227,566				5,573	227,566	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				60,481		60,481	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 294,908		\$	\$ 60,481	7,021	\$ 355,389	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	45,735		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	885,152		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,124		6
7	Other Prepaid Expenses	5,415		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 937,976	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	15,767		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,136,922		15
16	Equipment, at Historical Cost	279,016		16
17	Accumulated Depreciation (book methods)	(637,795)		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):	2,766		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,796,676	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,734,652	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 162,261	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	180,637		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,399		32
33	Accrued Interest Payable			33
34	Deferred Compensation	2,916		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	44,676		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 460,889	\$	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>	1,637,425		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,637,425	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,098,314	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 636,338	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,734,652	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 340,387	1
2	Restatements (describe):	196,475	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 536,862	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	99,476	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)	\$ 99,476	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)	\$ 636,338	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Montebello Healthcare Center

0047340

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	\$ 11,352,764	1
2	Discounts and Allowances for all Levels	(8,084,653)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,268,111	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	677,359	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 677,359	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	75,891	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,744	19
20	Radiology and X-Ray	2,492	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 83,127	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Receipts</u>	627	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 627	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,029,224	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	701,002	31
32	Health Care	1,865,033	32
33	General Administration	840,114	33
	B. Capital Expense		
34	Ownership	256,833	34
	C. Ancillary Expense		
35	Special Cost Centers	71,177	35
36	Provider Participation Fee	195,589	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,929,748	40
41	Income before Income Taxes (line 30 minus line 40)**	99,476	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 99,476	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,766,066	44
45	Private Pay - Net Inpatient Revenue	681,648	45
46	Medicare - Net Inpatient Revenue	802,007	46
47	Other-(specify) <u>HMO/Insurance</u>	2,061	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	16,329	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,268,111	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	1,147	1,192	\$ 42,596	\$ 35.73	1
2	Assistant Director of Nursing	624	786	18,086	23.01	2
3	Registered Nurses	14,337	15,363	371,660	24.19	3
4	Licensed Practical Nurses	10,763	11,699	215,656	18.43	4
5	CNAs & Orderlies	37,223	41,602	489,951	11.78	5
6	CNA Trainees					6
7	Licensed Therapist	6,711	7,033	294,908	41.93	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,707	1,832	27,076	14.78	9
10	Activity Assistants	1,292	1,326	12,652	9.54	10
11	Social Service Workers	1,984	2,096	44,522	21.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	585	838	5,610	6.69	14
15	Cook Helpers/Assistants	508	797	4,726	5.93	15
16	Dishwashers					16
17	Maintenance Workers	1,712	1,895	33,408	17.63	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,992	2,168	82,816	38.20	20
21	Assistant Administrator					21
22	Other Administrative	2,932	3,271	63,207	19.32	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,827	2,068	22,056	10.67	31
32	Other Health Care Medicare Coord	1,805	2,098	29,314	13.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,149	96,064	\$ 1,758,244 *	\$ 18.30	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		\$ 215,488	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		67,873		38
39	Pharmacist Consultant		6,071	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		3,736	11-3	44
45	Social Service Consultant		2,737	12-3	45
46	Other(specify)			10-3	46
47	XRay & Laboratory		9,504	39-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 312,609		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.

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 \$9,094

(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.

\$ 31,456

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.

\$ 195,589

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 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?

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