

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 # 271 847 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 01/01/2020 to 12/31/2020
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) SVP Operations Finance

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: 01/01/2020 Ending: 12/31/2020

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>9,725</u>	<u>2,146</u>	<u>2,397</u>	<u>14,268</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>9,725</u>	<u>2,146</u>	<u>2,397</u>	<u>14,268</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 28.05%

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

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

N/A

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 1,997

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2020 Ending: 12/31/2020
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		1,550	304,376	305,926		305,926	(53,648)	252,278			1
2	Food Purchase		1,266		1,266		1,266	53,607	54,873			2
3	Housekeeping		3,011	103,350	106,361		106,361		106,361			3
4	Laundry		1,907	67,544	69,451		69,451		69,451			4
5	Heat and Other Utilities			92,823	92,823		92,823	(5,734)	87,089			5
6	Maintenance	46,832	39,141	15,086	101,059		101,059	14,262	115,321			6
7	Other (specify):*			8,383	8,383		8,383	17,526	25,909			7
8	TOTAL General Services	46,832	46,875	591,562	685,269		685,269	26,013	711,282			8
	B. Health Care and Programs											
9	Medical Director			12,210	12,210		12,210		12,210			9
10	Nursing and Medical Records	1,139,311	98,409	44,517	1,282,237		1,282,237	136,560	1,418,797			10
10a	Therapy	336,888	9,214	21,276	367,378		367,378		367,378			10a
11	Activities	28,231	2,227	3,437	33,895		33,895		33,895			11
12	Social Services	46,719		2,763	49,482		49,482		49,482			12
13	CNA Training											13
14	Program Transportation	32,246	10,085	(578)	41,753		41,753		41,753			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,583,395	119,935	83,625	1,786,955		1,786,955	136,560	1,923,515			16
	C. General Administration											
17	Administrative	110,489		41,725	152,214		152,214	2,299	154,513			17
18	Directors Fees											18
19	Professional Services			5,415	5,415		5,415	11,375	16,790			19
20	Dues, Fees, Subscriptions & Promotions			35,365	35,365		35,365	(4,989)	30,376			20
21	Clerical & General Office Expenses	84,252	6,531	273,909	364,692		364,692	(210,629)	154,063			21
22	Employee Benefits & Payroll Taxes			386,764	386,764		386,764	19,575	406,339			22
23	Inservice Training & Education											23
24	Travel and Seminar			36,534	36,534		36,534	(31,690)	4,844			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,846	38,846		38,846	15,553	54,399			26
27	Other (specify):*											27
28	TOTAL General Administration	194,741	6,531	818,558	1,019,830		1,019,830	(198,506)	821,324			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,824,968	173,341	1,493,745	3,492,054		3,492,054	(35,933)	3,456,121			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			42,598	42,598		42,598	(21,360)	21,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12	12		12	21,946	21,958			32
33	Real Estate Taxes			69,306	69,306		69,306	1,664	70,970			33
34	Rent-Facility & Grounds			29,829	29,829		29,829		29,829			34
35	Rent-Equipment & Vehicles			600	600		600		600			35
36	Other (specify):*							16,502	16,502			36
37	TOTAL Ownership			142,345	142,345		142,345	18,752	161,097			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,428	2,644	48,072		48,072		48,072			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,131	161,131		161,131		161,131			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		45,428	163,775	209,203		209,203		209,203			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,824,968	218,769	1,799,865	3,843,602		3,843,602	(17,181)	3,826,421			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	(5,763)	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	(41)	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	(16,255)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	17,526	7		24
25	Fund Raising, Advertising and Promotional	(2,650)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,183)		\$	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)	241,664		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 241,664		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 234,481		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	Back Office Services	\$ (196,432)	21	1
2	Prof Liability Insurance Adjustment	8,128	26	2
3	Depreciation Adj - Capital Lease Days	(21,360)	30	3
4	Reclass Raw Food Expense	(53,648)	1	4
5	Reclass Raw Food Expense	53,648	2	5
6	Real Estate Accrual Adj	1,664	33	6
7	Rremove Travel Expense	(41,012)	24	7
8	Non Allowable Advertising	(2,650)	20	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	(251,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center# 0047340

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	(53,648)	0	0	0	0	0	0	0	0	0	0	(53,648)	1
2	Food Purchase	53,607	0	0	0	0	0	0	0	0	0	0	53,607	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	(5,763)	29	0	0	0	0	0	0	0	0	0	(5,734)	5
6	Maintenance	0	14,262	0	0	0	0	0	0	0	0	0	14,262	6
7	Other (specify):*	17,526	0	0	0	0	0	0	0	0	0	0	17,526	7
8	TOTAL General Services	11,722	14,291	0	0	0	0	0	0	0	0	0	26,013	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	136,560	0	0	0	0	0	0	0	0	0	136,560	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	136,560	0	0	0	0	0	0	0	0	0	136,560	16
	C. General Administration													
17	Administrative	0	2,299	0	0	0	0	0	0	0	0	0	2,299	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,375	0	0	0	0	0	0	0	0	0	11,375	19
20	Fees, Subscriptions & Promotions	(5,300)	311	0	0	0	0	0	0	0	0	0	(4,989)	20
21	Clerical & General Office Expenses	(212,687)	2,058	0	0	0	0	0	0	0	0	0	(210,629)	21
22	Employee Benefits & Payroll Taxes	0	19,575	0	0	0	0	0	0	0	0	0	19,575	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(41,012)	9,322	0	0	0	0	0	0	0	0	0	(31,690)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	8,128	7,425	0	0	0	0	0	0	0	0	0	15,553	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(250,871)	52,365	0	0	0	0	0	0	0	0	0	(198,506)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(239,149)	203,216	0	0	0	0	0	0	0	0	0	(35,933)	29

Summary B

12/31/2020

[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 Vernon	SSC Administrative Services LLC		Back Office Service
		Odin Health Care Center	Odin	SSC Consulting Services LLC		Consulting Services
		Westchester Healthcare Center0	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%	\$ 29	\$ 29	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	14,262	14,262	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	11,375	11,375	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	311	311	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	136,560	136,560	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	2,058	2,058	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	9,322	9,322	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	7,425	7,425	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	16,502	16,502	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	2,299	2,299	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%	21,946	21,946	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	19,575	19,575	13
14	Total			\$			\$ 241,664	\$ * 241,664	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:

01/01/2020

Ending:

12/31/2020

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		Excell Health Care Center	Oakland				1
2			Flagship Heath care Center	Newport Beach				2
3			Tarzana Health & Rehab Center	Tarzana				3
4			Diamond Ridge Health Care Center	Pittsburgh				4
5			Courtyard Care Center	San Jose				5
6			Mission Carmichael Health Care Center	Carmichael				6
7			AlpineLiving Center	Thornton				7
8			Boulder Manor	Boulder				8
9			Pearl Street Health Care Center	Englewood				9
10			Applewood Living Center	Longmont				10
11			Fort Collins Health Care Center	Fort Collins				11
12			Spring Creek Healthcare Center	Fort Collins				12
13			Berthoud Living Center	Berthoud				13
14			Sierra Vista Health Care Center	Loveland				14
15			Windsor Health Care Center	Windsor				15
16			San Juan Living Center	Montrose				16
17			Four Corners Health Care Center	Durango				17
18			Palisade Living Center	Palisade				18
19			Colonial Columns Nursing Center	Colorado Springs				19
20			Cedarwood Health Care Center	Colorado Springs				20
21			Minnequa Medcenter	Pueblo				21
22			Terrace Gaedens Healthcare Center	Colorado Springs				22
23			Aspen Living Cente	Colorado Springs				23
24			Centennial Heathcare Center	Greeley				24
25			Kenton Manor	Greeley				25
26			Stering Living Center	Sterling				26
27			Sunset Manor	Brush				27
28			Yuma Life Care Center	Yuma				28
29			Jewell Care Center of Denver	Denver				29
30			Monaco Parkway	Denver				30

Facility Name & ID Number

Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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		Garden Square at Spring Creek	Fort Collins				1
2			Pendleton Health & Rehab	Mystic				2
3			Bride Brook Health & Rehab	Niantic				3
4			Brian Center Nursing Care Austell	Austill				4
5			Brian Center Health & Rehab Canton	Canton				5
6			Northeast Atlanta Healty & Rehab	Atlanta				6
7			Brighton Place West	Topeka				7
8			Indian Creek Healht Care Center	Overland Park				8
9			SE Massachusetts Health & Rehab	New Bedford				9
10			Methuen Health & Rehab Center	Methuen				10
11			Patuxent River Health & Rehab Center	Laurel				11
12			Arcola Heatlh & Rehab Center	Silver Spring				12
13			Glen Burnie Health & Rehab Center	Glen Burnie				13
14			Overlea Health & Rehab Center	Baltimore				14
15			Bethesda Health & Rehab Center	Bethesda				15
16			Summit Park Health & Rehab Center	Catonsville				16
17			North Arundel Health & Rehab Center	Glen Burnie				17
18			Bel Air Health & Rehab Center	Bel Air				18
19			Forest Hill Health & Rehab Center	Forest Hill				19
20			Heritage Harbour Health & Rehab Center	Annapolis				20
21			Cambridge East	Madison Heights				21
22			Cambridge North	Clawson				22
23			Cambridge South	Beverly Hills				23
24			Clarkston	Clarkston				24
25			Clinton-Aire Healthcare Center	Clinton Township				25
26			Crestmont NursingCare Center	Fenton				26
27			Heritage Manor	Flint				27
28			Hope Health Care Center	Westland				28
29			Warren Woods Health Care Center	Warren				29
30			Superior Woods Health Care Center	Ypsilanti				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	Countrybrook Living Center	Brook Haven				1
2			Brian Center Health & Rehab Eden	Eden				2
3			Brian Center Nursing Care Lexington	Lexington				3
4			Brian Center Health & Rehab Hickory East	Hickory				4
5			Brian Center Health & Rehab Wilson	Wilson				5
6			Randolph Health & Rehab Center	Asheboro				6
7			Brian Center Health & Rehab Winston Salem	Winston Salem				7
8			Brian Center Health & RehabCharlotte	Charlotte				8
9			Brian Center Health & Rehab Windsor	Windsor				9
10			Maple Leaf Health Care	Statesville				10
11			Brian Center Health & Rehab Weaverville	Weaverville				11
12			Brian Center Health & Rehab Lincolnton	Lincolnton				12
13			Brian Center Health & Rehab Wallace	Wallace				13
14			Brian Center Health & Rehab Monroe	Monroe				14
15			Brian Center Health & RehabDurham	Durham				15
16			Brian Center Health & Rehab Goldsboro	Goldsboro				16
17			Brian Center Health & Rehab Cabarrus	Concord				17
18			Brian Center Nursing Care Shamrock	Charlotte				18
19			Brian Center Nursing Care Hickory	Hickory				19
20			Brian Center Health & Rehab Center Waynesvi	Waynesville				20
21			Brian Center Health & Rehab Clayton	Clayton				21
22			Brian Center Health & Rehab Brevard	Bervard				22
23			Brian Center Health & Rehab Yanceyville	Yanceyville				23
24			Brian Center Health & Rehab Hertford	Hertford				24
25			Brian Center Health & Rehab Spruce Pine	Spruce Pine				25
26			Brian Center Health & Rehab Hendersonville	Hendersonville				26
27			Brian Center Health & Rehab Salisbury	Salisbury				27
28			Mariner Health Care of Wilmington	Wilmington				28
29			Silver Stream Health & Rehab	Wilmington				29
30			Kenansville Health & Rehab	Kenansville				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	<u>SSC Equity Holding Company LLC</u>	<u>100</u>	<u>Charlotte Apts</u>	<u>Charlotte</u>				1
2			<u>Forest City Health & Rehab</u>	<u>Forest City</u>				2
3			<u>North Hills Health & Rehab</u>	<u>Wexford</u>				3
4			<u>West Hills Health & Rehab</u>	<u>Coraopolis</u>				4
5			<u>Broomall Health & Rehab</u>	<u>Broomall</u>				5
6			<u>Seneca Health & Rehab</u>	<u>Senaca</u>				6
7			<u>Sumter East Health & Rehab</u>	<u>Sumter</u>				7
8			<u>Golden Age Inman</u>	<u>Inman</u>				8
9			<u>Inman Healthcare</u>	<u>Inman</u>				9
10			<u>Lebanon Health & REhab</u>	<u>Lebanon</u>				10
11			<u>Greenhills Health & Rehab</u>	<u>Nashville</u>				11
12			<u>Norris Health & Rehab</u>	<u>Andersonville</u>				12
13			<u>Newport Health & Rehab</u>	<u>Newport</u>				13
14			<u>Cheyenne Healthcare</u>	<u>Cheyenne</u>				14
15			<u>Poplar Living Center</u>	<u>Casper</u>				15
16			<u>Sheridan Manor</u>	<u>Sheridan</u>				16
17			<u>Huntington Health Care</u>	<u>Huntington</u>				17
18			<u>Bastrop Nursing Center</u>	<u>Bastrop</u>				18
19			<u>Care Inn of La Grange</u>	<u>La Grange</u>				19
20			<u>Kountze Nursing Center</u>	<u>Kountze</u>				20
21			<u>Retama Manor Nursing Center San Antonio No</u>	<u>San Antonio</u>				21
22			<u>Retama Manor Nursing Center San Antonio We</u>	<u>San Antonio</u>				22
23			<u>Retama Manor Nursing Center Alice</u>	<u>Alice</u>				23
24			<u>Retama Manor Nursing Center Edinburg</u>	<u>Edinburg</u>				24
25			<u>Retama Manor Nursing Center Harlingen</u>	<u>Harlingen</u>				25
26			<u>Retama Manor Nursing Center Jourdanton</u>	<u>Jourdanton</u>				26
27			<u>Retama Manor Nursing Center Laredo South</u>	<u>Laredo</u>				27
28			<u>Retama Manor Nursing Center Laredo West</u>	<u>Laredo</u>				28
29			<u>Retama Manor Nursing Center McAllen</u>	<u>McAllen</u>				29
30			<u>Retama Manor Nursing Center Pleasanton Nort</u>	<u>Pleasanton</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	Retama Manor Nursing Center Pleasanton Sout Pleasanton					1
2			Retama Manor Nursing Center Rio Grande City	Rio Grande City				2
3			Retama Manor Nursing Center Robstown	Robstown				3
4			Retama Manor Nursing Center Weslaco	Weslaco				4
5			Weatherford health Care Center	Weatherford				5
6			Peach Tree Place	Weatherford				6
7			Retama Manor Nursing Center Raymondville	Raymondville				7
8			Memorial City Health and Rehab	Houston				8
9			Jacinto City Healthcare Center	Houston				9
10			Spring Branch Healthcare Center	Houston				10
11			Retama Manor Nursing Center Corpus Christi	Corpus Christi				11
12			Downtown Health & Rehab	Fort Worth				12
13			Lakeshore Village Healthcare Center	Waco				13
14			Deer Creek of Wimberley	Wimberley				14
15			La Paloma Nursing Center	San Diego				15
16			Pine Arbor	Silsbee				16
17			Las Palmas Healthcare Center	McAllen				17
18			Hilltop Village	Kerville				18
19			Silver Creek Manor	San Antonio				19
20			Alpine Terrace	Kerrville				20
21			Edgewater Care Center	Kerrville				21
22			Arlington Heights Health & Rehab	Fort Worth				22
23			The Meadows Health & Rehab	Dallas				23
24			Northgate Health & Rehab	San Antonio				24
25			Interlochen Health & Rehab	Arlington				25
26			First Colony Health & Rehab	Missouri City				26
27			Cypresswood Health & Rehab	Houston				27
28			Northwest Health & Rehab	Houston				28
29			The Westbury Place	Houston				29
30			Westchase Health & Rehab	Houston				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	Woodwind Lakes Health & Rehab	Houston				1
2			Pasadena Care Center	Pasadena				2
3			Bay Villa	Bay City				3
4			Alice Health care Center	Alice				4
5			Bangs Nursing Home	Bangs				5
6			Brazosview	Richmond				6
7			Courtyards at Fort Worth	Fort Worth				7
8			Faith Memorial	Pasadena				8
9			Golden Years	Marlin				9
10			Greenview Manor	Waco				10
11			Hillview Health & Rehab	Goldthwaite				11
12			Levelland Health Care	Levelland				12
13			Longmeadow Health Care	Justin				13
14			Memorial Medical Nursing Center	San Antonio				14
15			Mount Pleasant	Mount Pleasant				15
16			North Park Health & Rehab	McKinney				16
17			Pampa Health Care Center	Pampa				17
18			Park Highlands Health Care Center	Athens				18
19			Pleasant Springs Health Care Center	Mount Pleasant				19
20			Sweeny Health Care Center	Sweeny				20
21			Texoma Health Care Center	Sherman				21
22			The Park in Plano	Plano				22
23			Ashland Health & Rehab	Ashland				23
24			Southpointe Health Care Center	Greenfield				24
25			Virginia Highlands Health & Rehab Center	Germantown				25
26			Grande Prairie Health & Rehab Center	Pleasant Prairie				26
27			Pleasant Valley Health Care Center	Derry				27
28			The Village at Alameda	Albuquerque				28
29			Hobbs Healthcare Center	Hobbs				29
30			Lake Mead Health Care Center	Henderson				30

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	76,991	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	70,670	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(6,321)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	69,006	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.				\$	62,685	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	68,287	8	FOR BHF USE ONLY	
		2016	70,574	9		
		2017	67,671	10	13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
		2018	67,671	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2019	70,670	12	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.

FACILITY NAME Montebello Healthcare Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0047340

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

25,581

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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

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

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

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 207,409	\$		\$	\$	\$ 207,409	1
2	Fire Alarm / Air Handler	2011	348		10			348	2
3	Install 2 Roof Top Units	2011	15,694		10			15,694	3
4	20 Wood Blinds	2011	2,964		5			2,964	4
5	17 Room Signs	2011	627		5			627	5
6	Shirred Valances and Rods	2011	2,912		5			2,912	6
7	Replace Tile & Vinyl flooring, walls, plumbing, & paint in 15 resic	2011	138,295		15			138,295	7
8	Replace electrical wiring and crown molding	2011	8,467		15			8,467	8
9									9
10	2 3 Ton Min Split Systems	2012	13,456		5			13,456	10
11	Commercial Disposal	2012	1,042		5			1,042	11
12									12
13	Stair Rail Panels	2013	1,991		4			1,991	13
14	Electrical for New Range	2013	1,285		3.75			1,285	14
15	NW Wing RTU Evaporator Coil	2013	2,986		3.4			2,986	15
16	Walk InCooler Compressor	2013	1,193		3.4			1,193	16
17	Nortstar Phone System	2013	15,745		3.4			15,745	17
18	A/C Blower Motor	2013	959		3.25			959	18
19									19
20	Polycom Phones	2014	521		3			521	20
21									21
22	CMBS Parking Curbs and Signs	2015	4,330		2			4,330	22
23	CMBS Strobe Fire Alarm Device	2015	2,000	200	10	200		1,250	23
24	CMBS Toilet Rooms	2015	1,400	120	11.66	120		750	24
25	CMBS Windows and Frame Replace	2015	1,320	113	11.66	113		707	25
26	Electrical Conduit	2015	2,064	166	12.42	166		1,164	26
27	50 ESA36-5, 3 Phase U	2015	6,418	214	5	214		6,418	27
28	Fire Panel	2015	2,387	239	5	239		1,313	28
29									29
30	Mounting Gasket for Commercial Disposal	2016	30	6	5	6		28	30
31	Commercial Disposal	2016	1,079	216	5	216		1,026	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 436,922	\$ 1,274		\$ 1,274	\$	\$ 432,880	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 436,922	\$ 1,274		\$ 1,274	\$	\$ 432,880	1
2	Demo and rebuild shower room - drywall, floors, plumbing	2017	27,238	1,816	15	1,816		7,415	2
3	Cleanspace liners, DryTrak, &labor for basement drainage	2017	4,475	25	15	298	273	1,026	3
4									4
5	5 Ton AC Unit - Laundry	2018	2,962	592	5	592		1,481	5
6	6 Ton Carrier RTU	2018	7,968	797	10	797		1,992	6
7	6T Carrier RTU-Mid Center Hall	2018	7,968	797	10	797		1,859	7
8									8
9	2: 5T A/C System - N&S Kitchen	2019	10,585	1,059	10	1,059		1,676	9
10	6 T Carrier RTU - SE Wing	2019	8,280	828	10	828		1,173	10
11	Accelerator - Dry Fire System	2019	2,335	234	10	234		409	11
12									12
13	Norstar 0x8 Telephone System	2020	1,286	118	10	118		118	13
14	425 Sprinkler Heads for Building	2020	15,722	524	10	524		524	14
15	90 Minute Fire Rated Door	2020	2,975	25	20	25		25	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 528,716	\$ 8,089		\$ 8,362	\$ 273	\$ 450,578	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	\$282,157	\$11,103	\$	\$(11,103)		\$229,563	71
72	Current Year Purchases	1,630	146		(146)		146	72
73	Fully Depreciated Assets	(6,761)						73
74								74
75	TOTALS	\$277,026	\$11,249	\$	\$(11,249)		\$229,709	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)	\$805,742	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$19,338	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$8,362	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(10,976)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$680,287	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:SSC Equity Holdings LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	139	10/16/2013	\$29,828	12		3
4	Additions							4
5								5
6								6
7	TOTAL		139		\$29,828			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☒ X 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

10. Effective dates of current rental agreement:
Beginning06/02/2014
Ending05/31/2026

11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2021 | \$ |
| 13. | /2022 | \$ |
| 14. | /2023 | \$ |

* 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	3331 hrs	\$ 110,727		\$	\$	3,331	\$ 110,727	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs							2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	5226 hrs	220,852				5,226	220,852	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				45,428		45,428	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			\$ 331,579		\$	\$ 45,428	8,557	\$ 377,007	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	\$ 550	\$	1
2	Cash-Patient Deposits	7,007		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	280,875		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	431		6
7	Other Prepaid Expenses	4,402		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 293,265	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,937		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	528,717		15
16	Equipment, at Historical Cost	283,540		16
17	Accumulated Depreciation (book methods)	(705,447)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 112,747	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 406,012	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 540,641	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	272,045		30
31	Accrued Taxes Payable (excluding real estate taxes)	56,699		31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,667		32
33	Accrued Interest Payable			33
34	Deferred Compensation	3,530		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accured Other	17,134		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 960,716	\$	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	Intercompany	(178,041)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (178,041)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 782,675	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (376,663)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 406,012	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (460,742)	1
2	Restatements (describe):	(988)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (461,730)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	85,067	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)	\$ 85,067	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)	\$ (376,663)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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	\$ 11,988,658	1
2	Discounts and Allowances for all Levels	(8,914,882)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,073,776	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	801,094	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 801,094	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	53,406	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	363	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 53,769	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>General Rental Receipts</u>		28
28a	<u>Misc Receipts Vending/Activities</u>	30	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,928,669	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	685,269	31
32	Health Care	1,786,955	32
33	General Administration	1,019,830	33
	B. Capital Expense		
34	Ownership	142,345	34
	C. Ancillary Expense		
35	Special Cost Centers	48,072	35
36	Provider Participation Fee	161,131	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,843,602	40
41	Income before Income Taxes (line 30 minus line 40)**	85,067	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 85,067	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,396,208	44
45	Private Pay - Net Inpatient Revenue	455,154	45
46	Medicare - Net Inpatient Revenue	593,045	46
47	Other-(specify) <u>HMO/Ins</u>	4,730	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	624,639	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,073,776	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	1,871	2,125	\$ 97,686	\$ 45.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,685	5,192	181,185	34.90	3
4	Licensed Practical Nurses	12,298	13,545	363,859	26.86	4
5	CNAs & Orderlies	25,876	28,198	446,309	15.83	5
6	CNA Trainees					6
7	Licensed Therapist	7,649	8,576	336,888	39.28	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,390	1,550	28,231	18.21	9
10	Activity Assistants					10
11	Social Service Workers	1,847	2,131	46,719	21.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,783	1,895	46,832	24.71	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,079	2,297	106,489	46.36	20
21	Assistant Administrator					21
22	Other Administrative	2,039	2,095	88,252	42.13	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	2,452	2,682	50,272	18.74	31
32	Other Health Care(specify)	1,930	2,000	32,246	16.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	65,899	72,286	\$ 1,824,968 *	\$ 25.25	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 299,954	1-3	35
36	Medical Director		12,210	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,690	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		2,819	11-3	44
45	Social Service Consultant		2,763	12-3	45
46	Other(specify)				46
47	Administrative		41,721	10-3	47
48	Laboratory & Xray		2,379	39-3	48
49	TOTAL (lines 35 - 48)		\$ 367,536		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Jonni R Bullington	Administrator	0	\$ 25,840	Workers' Compensation Insurance	\$ 66,685	IDPH License Fee	\$		
Jonathan B Burstyn	Administrator	0	14,051	Unemployment Compensation Insurance	8,074	Advertising: Employee Recruitment	9,717		
David A Mac-Rizzo	Administrator	0	22,012	FICA Taxes	136,715	Health Care Worker Background Check	4,645		
Thomas E Ohnemus	Administrator	0	5,103	Employee Health Insurance	164,303	(Indicate # of checks performed _____)			
William R Watson	Administrator	0	25,969	Employee Meals		Patient Background Checks			
Rachael A Woodside	Administrator	0	17,514	Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	547		
				Life Insurance	684	Dues	11,928		
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits - EE Relations	10,303	Other Licenses	5,878		
(List each licensed administrator separately.) \$ 110,489				Home Office Payroll Tzses	19,575	Fees, Subscriptions and Promos	311		
B. Administrative - Other									
Description			Amount			Less: Public Relations Expense	()		
Internal Chargeouts - Admin			\$ 41,725			Non-allowable advertising	(2,650)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 41,725	TOTAL (agree to Schedule V, line 22, col.8)		\$ 406,339	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 30,376	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type	Amount					Out-of-State Travel	\$	
Equifax	Background Checks	\$ 710							
Lexis Nexis	Regs Resource	35							
NRC Health	Survey Program	177							
Accelerate Consulting	International Recruitment	1,000					In-State Travel		
Avalere Health	Vantage CPS	443							
Bradley Associates	RE Appraisal	1,545							
Docusign Inc	New Hire Paperwork	74							
Management Network Svcs	Network Membership	375					Seminar Expense	4,844	
Pinnacle Quality Insights	Cust Satisfaction Survey	1,056							
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) \$ 5,415							TOTAL	\$ 4,844	

*** Attach copy of IMRF notifications**

****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 \$10,971
- (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. \$ 15,592 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. _____
- (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. \$ 162,131
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ Yes
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman LLC (Corporate Level)
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NA
Attach invoices and a summary of services for all architect and appraisal fees.