

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841 Report Period Beginning: 08/01/01 Ending: 07/31/02

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	25	Skilled (SNF)	25	9,125	1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	15		2,371	2,386	8
9	SNF/PED					9
10	ICF	16,044	9,490		25,534	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,059	9,490	2,371	27,920	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.27%

D. How many bed-hold days during this year were paid by Public Aid? 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)

OUTPATIENT THERAPY

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 10/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES Date SEE ATTACHED NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 9 and days of care provided 2,371

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 07/31/02 Fiscal Year: 07/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number SUNRISE MANOR OF VIRDEN # 0025841 Report Period Beginning: 08/01/01 Ending: 07/31/02

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	86,695	10,910	5,417	103,022		103,022		103,022		1
2	Food Purchase		101,541		101,541		101,541	(1,783)	99,758		2
3	Housekeeping	25,208	8,942		34,150		34,150		34,150		3
4	Laundry	25,717	9,105		34,822		34,822		34,822		4
5	Heat and Other Utilities			76,666	76,666		76,666		76,666		5
6	Maintenance	24,512	24,251	37,426	86,189		86,189	1,285	87,474		6
7	Other (specify):* UTILITY WORKERS	18,063			18,063		18,063		18,063		7
8	TOTAL General Services	180,195	154,749	119,509	454,453		454,453	(498)	453,955		8
B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	752,940	71,135	9,863	833,938	(49,390)	784,548	4,168	788,716		10
10a	Therapy	18,524	524	208,093	227,141	(206,710)	20,431		20,431		10a
11	Activities	25,859	1,134		26,993		26,993		26,993		11
12	Social Services	3,788		2,910	6,698		6,698		6,698		12
13	Nurse Aide Training	12,002		150	12,152		12,152	(5,417)	6,735		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	813,113	72,793	228,216	1,114,122	(256,100)	858,022	(1,249)	856,773		16
C. General Administration											
17	Administrative	58,260		10,906	69,166	2,029	71,195	37,577	108,772		17
18	Directors Fees										18
19	Professional Services			210,340	210,340		210,340	(201,976)	8,364		19
20	Dues, Fees, Subscriptions & Promotions			14,023	14,023		14,023	(3,711)	10,312		20
21	Clerical & General Office Expenses	22,608	7,726	6,335	36,669		36,669	22,175	58,844		21
22	Employee Benefits & Payroll Taxes			161,985	161,985		161,985	13,162	175,147		22
23	Inservice Training & Education			1,159	1,159		1,159	268	1,427		23
24	Travel and Seminar			3,401	3,401	(3,153)	248	469	717		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			109,242	109,242		109,242	477	109,719		26
27	Other (specify):*			11,284	11,284		11,284	(11,284)			27
28	TOTAL General Administration	80,868	7,726	528,675	617,269	(1,124)	616,145	(142,843)	473,302		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,074,176	235,268	876,400	2,185,844	(257,224)	1,928,620	(144,590)	1,784,030		29

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

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

Facility Name & ID Number SUNRISE MANOR OF VIRDEN #0025841 Report Period Beginning: 08/01/01 Ending: 07/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation					23,577	23,577	31,815	55,392		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							898	898		32
33	Real Estate Taxes			19,642	19,642		19,642		19,642		33
34	Rent-Facility & Grounds			245,400	245,400		245,400	(236,991)	8,409		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* DEPRECIATION			23,577	23,577	(23,577)					36
37	TOTAL Ownership			288,619	288,619		288,619	(204,278)	84,341		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					257,224	257,224		257,224		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			54,203	54,203		54,203		54,203		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			54,203	54,203	257,224	311,427		311,427		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,074,176	235,268	1,219,222	2,528,666		2,528,666	(348,868)	2,179,798		45

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

Facility Name & ID Number **SUNRISE MANOR OF VIRDEN**

0025841

Report Period Beginning: **08/01/01**

Ending: **07/31/02**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,192)	30		9
10	Interest and Other Investment Income	(1,818)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,053)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,961)	27		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				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	(6,243)	27		24
25	Fund Raising, Advertising and Promotional	(3,830)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,080)	27		26
27	Nurse Aide Training for Non-Employees	(5,417)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>VENDING</u>	(1,783)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,377)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(307,491)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (307,491)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (348,868)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39	<u>THERAPY</u>	X		206,710	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		207	10	42
43	Prescription Drugs	X		44,572	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>MED SUPP</u>	X		541	10	45
46	Other-Attach Schedule <u>OXYGEN</u>	X		5,194	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 257,224		47

SUNRISE MANOR OF VIRDEN

ID# 0025841

Report Period Beginning: 08/01/01

Ending: 07/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

08/01/01

Ending:

07/31/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	Nurse Aide Training	(5,417)	0	0	0	0	0	0	0	0	0	0	(5,417)	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	(5,417)	0	0	0	0	0	0	0	0	0	0	(5,417)	16
	C. General Administration													
17	Administrative	0	211	0	0	0	0	0	0	0	0	0	211	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(202,510)	0	0	0	0	0	0	0	0	0	(202,510)	19
20	Fees, Subscriptions & Promotions	(3,830)	0	0	0	0	0	0	0	0	0	0	(3,830)	20
21	Clerical & General Office Expenses	(1,053)	0	0	0	0	0	0	0	0	0	0	(1,053)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(211)	0	0	0	0	0	0	0	0	0	(211)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(11,284)	0	0	0	0	0	0	0	0	0	0	(11,284)	27
28	TOTAL General Administration	(16,167)	(202,510)	0	0	0	0	0	0	0	0	0	(218,677)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,584)	(202,510)	0	0	0	0	0	0	0	0	0	(224,094)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNRISE MANOR OF VIRDEN# 0025841

Report Period Beginning:

08/01/01

Ending:

07/31/02

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(16,192)	46,349	0	0	0	0	0	0	0	0	0	30,157 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,818)	2,716	0	0	0	0	0	0	0	0	0	898 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(241,200)	0	0	0	0	0	0	0	0	0	(241,200) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(18,010)	(192,135)	0	(210,145) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(39,594)	(394,645)	0	(434,239) 45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN	41.0	D'ADRIAN CONVALESCENT CENTER, INC	GODFREY	NursingHome Mngrs	SPRINGFIELD	MANAGEMENT
H. RAYMOND KLEIN	36.5	HILLTOP NURSING HOME, INC	CHARLESTON	Sunrise Property	SPRINGFIELD	LEASOR
PHILIP KLEIN	4.5	JACKSONVILLE CONVALESCENT CENTER, INC	JACKSONVILLE			
DANA KLEIN KAVY	4.5	MEADOW MANOR, INC	TAYLORVILLE			
LISA KLEIN GILDAR	4.5	MENARD CONVALESCENT CENTER, INC.	PETERSBURG			
DAVID & RAQUEL KLEIN	4.5					
JERRY & PAULA JENNINGS	4.5					

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	34 RENT	\$ 241,200	SUNRISE PROPERTY	100.00%	\$	\$ (241,200)
2	V	30 DEPRECIATION		SUNRISE PROPERTY	100.00%	46,349	46,349
3	V	32 INTEREST		SUNRISE PROPERTY	100.00%	2,716	2,716
4	V						
5	V	19 MANAGEMENT FEE	210,340	NURSING HOME MANAGERS, INC	77.50%		(210,340)
6	V	VAR SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS, INC	77.50%	87,154	87,154
7	V	19 ACCOUNTING		NURSING HOME MANAGERS, INC - DIRECT ALLOCATION	77.50%	7,830	7,830
8	V	24 TRAVEL	211	TO TRANSFER 31% OF HOME OFFICE TRAVEL	77.50%		(211)
9	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE - PER DESK REVIEW	77.50%	211	211
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 451,751			\$ 144,260	\$ * (307,491)

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

Facility Name & ID Number SUNRISE MANOR OF VIRDEN # 0025841 Report Period Beginning: 08/01/01 Ending: 07/31/02

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	SAM KLEIN	PRESIDENT	MANAGEMENT	41.00					\$ 643	17 -7	1	
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	36.50					1,829	17 -7	2	
3	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.50					15,367	17 -7	3	
4											4	
5		Sam Klein, H. Raymond Klein, and Jerry Jennings were paid by Nursing Home										5
6		Managers, Inc., a related organization. Total compensation of \$3,272 for										6
7		Sam Klein and \$9,048 for H. Raymond Klein was allocated among the										7
8		six related nursing homes based upon 10 hours per week for Sam Klein										8
9		and 10 hours per week for H. Raymond Klein. For Jerry Jennings										9
10		\$76,170 of compensation was allocated among the related homes based										10
11		upon 35 hours per week.										11
12											12	
13								TOTAL	\$ 17,839		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 SUNRISE MANOR OF VIRDEN # 0025841 Report Period Beginning: 08/01/01 Ending: 07/31/02

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

Name of Related Organization NURSING HOME MANAGERS, INC.
 Street Address 2653 W. LAWRENCE - SUITE B
 City / State / Zip Code SPRINGFIELD, IL 62704
 Phone Number (217) 787-8530
 Fax Number (217) 787-9840

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	SEE ATTACHED SCHEDULES								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SUNRISE MANOR OF VIRDEN # 0025841 Report Period Beginning: 08/01/01 Ending: 07/31/02

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	OWNERS	X		ACQUISITION	VARIES	10/01/85	\$ 800,000	\$ 37,165	DEMAND	6.0000	\$ 2,716	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 800,000	\$ 37,165			\$ 2,716	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 800,000	\$ 37,165			\$ 2,716	15								

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

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

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

Facility Name & ID Number **SUNRISE MANOR OF VIRDEN**# **0025841** Report Period Beginning: **08/01/01** Ending: **07/31/02****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 2001 report.			\$	19,459	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.)			\$	8,981	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(10,478)	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	30,120	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.			\$	19,642	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1997	16,781	8		
		1998	16,648	9		
		1999	17,202	10		
		2000	17,963	11		
		2001	19,023	12		
LINE 2 - 2ND INSTALLMENT 2000 \$8981		LINE 4 - BOTH INST 2001 \$19,023				
		7/12 OF \$19,023		11,097		
		LINE 4		\$30,120		
13	FROM R. E. TAX STATEMENT FOR 2001	\$				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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNRISE MANOR OF VIRDEN COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0025841

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-000-148-01</u>	<u>SUNRISE MANOR</u>	\$ <u>19,023.40</u>	\$ <u>19,023.40</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>19,023.40</u>	\$ <u>19,023.40</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number SUNRISE MANOR OF VIRDEN# 0025841 Report Period Beginning:08/01/01 Ending:07/31/02**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 28,444 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	<u>NURSING HOME</u>		<u>1985</u>	\$ <u>5,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 5,000	3

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

08/01/01

Ending:

07/31/02

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1985	1970	\$ 885,000	\$ 46,020	30	\$ 29,500	\$ (16,520)	\$ 501,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		AIR CONDITIONING		1981	2,179		8			2,179	9
10		IMPROVEMENT		1981	5,664		15			5,664	10
11		AIR CONDITIONING		1983	1,734	11	10		(11)	1,734	11
12		EXHAUST FAN & IMPROVEMENT		1984	2,064		15			2,064	12
13		ROOF		1985	29,004	1,160	15		(1,160)	29,004	13
14		BLACKTOP		1985	16,000	672	15		(672)	16,000	14
15		LANDSCAPING		1985	2,400	101	10		(101)	2,400	15
16		TILE		1986	2,508	130	15	86	(44)	2,508	16
17		AIR CONDITIONING		1986	573	30	8		(30)	573	17
18		CIRCULATING PUMPS		1986	918	47	15	34	(13)	918	18
19		WATER HEATER		1987	1,705	54	15	53	(1)	1,705	19
20		SEWER & MANHOLE		1988	4,843	154	15	323	169	4,683	20
21		FIRE ALARM ADJUSTMENT		1989	1,388	44	15	93	49	1,254	21
22		SPRINKLER MAINTENANCE		1990	735	23	10		(23)	735	22
23		ROOF		1990	11,247	357	15	750	393	8,625	23
24		SPRINKLER & DETECTORS		1991	2,684	85	15	179	94	2,058	24
25		DOOR ALARM, TOILET, ETC.		1993	2,867	91	15	191	100	1,815	25
26		ROOF, AIR CONDITIONING, KITCHEN		1995	16,554	424	15	1,103	679	8,279	26
27		SMOKE DOORS		1997	4,043	104	15	269	165	1,214	27
28		ROOF		1998	10,655	273	15	710	437	3,196	28
29		DOOR FRAMES		1998	4,379	112	15	292	180	1,314	29
30		GUTTERS		1999	800	21	15	53	32	186	30
31		AIR CONDITIONING		1999	17,091	438	10	1,709	1,271	5,982	31
32		WATER HEATER, DOOR, PLUMBING		2000	13,377	344	15	892	548	2,251	32
33		AIR CONDITIONING		2001	2,606	59	15	159	100	159	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,043,018	\$ 50,754		\$ 36,396	\$ (14,358)	\$ 608,000		70

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

C. Equipment Depreciation-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	\$ 170,665	\$ 16,473	\$ 15,704	\$ (769)	VARIES	\$ 88,740	71
72	Current Year Purchases	23,469	2,699	1,634	(1,065)	VARIES	1,633	72
73	Fully Depreciated Assets	183,942					183,942	73
74								74
75	TOTALS	\$ 378,076	\$ 19,172	\$ 17,338	\$ (1,834)		\$ 274,315	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,426,094	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,926	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,734	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,192)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 882,315	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: SUNRISE PROPERTY
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1970</u>	<u>99</u>	<u>08/01/85</u>	\$ <u>241,200</u>	<u>1</u>	<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 241,200			7

10. Effective dates of current rental agreement:
 Beginning 08/01/01
 Ending 07/31/02

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>07/31/2003</u>	\$ <u>241,200</u>
13.	<u>07/31/2004</u>	\$ <u>241,200</u>
14.	<u>07/31/2005</u>	\$ <u>241,200</u>

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ _____ Description: INCLUDED IN ABOVE AMOUNT
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>84</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	469	1,476		1,945
4	Clinical Wages (b)		1,445		1,445
5	In-House Trainer Wages (c)	906	7,706		8,612
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		150		150
9	TOTALS	\$ 1,375	\$ 10,777	\$	\$ 12,152
10	SUM OF line 9, col. 1 and 2 (e)	\$ 12,152			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ 5,417

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	5
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	2
TOTAL TRAINED	17

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39-8	hrs	\$	984	\$ 71,978						984	\$ 71,978	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		90	8,542						90	8,542	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	39-8	hrs		1,732	126,190						1,732	126,190	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39-8	# of prescripts							44,572			44,572	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify): O2,LAB,MED SUPPL	39-8								5,942			5,942	13
14	TOTAL			\$	2,806	\$ 206,710				\$ 50,514		2,806	\$ 257,224	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number **SUNRISE MANOR OF VIRDEN**

0025841

Report Period Beginning: **08/01/01**

Ending:

07/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **07/31/02**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 277,697	\$ 327,510	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	315,220	315,220	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,083	25,083	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 618,000	\$ 667,813	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		5,000	13
14	Buildings, at Historical Cost		892,827	14
15	Leasehold Improvements, at Historical Cost	150,191	150,191	15
16	Equipment, at Historical Cost	228,175	376,675	16
17	Accumulated Depreciation (book methods)	(249,409)	(1,195,370)	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)	\$ 128,957	\$ 229,323	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 746,957	\$ 897,136	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 131,983	\$ 131,983	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		37,165	29
30	Accrued Salaries Payable	34,492	34,492	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,161	3,161	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,120	30,120	32
33	Accrued Interest Payable		189	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,080	3,080	35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 202,836	\$ 240,190	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 202,836	\$ 240,190	46
47	TOTAL EQUITY(page 18, line 24)	\$ 544,121	\$ 656,946	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 746,957	\$ 897,136	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 360,706	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 360,706	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	203,415	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	(20,000)	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)	\$ 183,415	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)	\$ 544,121	24 *

* This must agree with page 17, line 47.

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,629,252	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,629,252	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,186	6
7	Oxygen	475	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 88,661	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,008	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,008	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,818	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,818	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING \$1783 ADM FEE \$600 W/A \$36	2,419	28
28a	Bad Debt Rec \$1506 Old Cks \$284 II Treas \$133	1,923	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,342	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,732,081	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	454,453	31
32	Health Care	1,114,122	32
33	General Administration	617,269	33
B. Capital Expense			
34	Ownership	288,619	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,528,666	40
41	Income before Income Taxes (line 30 minus line 40)**	203,415	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 203,415	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **SUNRISE MANOR OF VIRDEN**# **0025841**Report Period Beginning: **08/01/01**Ending: **07/31/02**

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	1,920	2,000	\$ 42,394	\$ 21.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,806	4,085	68,639	16.80	3
4	Licensed Practical Nurses	17,484	18,407	234,710	12.75	4
5	Nurse Aides & Orderlies	45,438	46,180	407,197	8.82	5
6	Nurse Aide Trainees	657	657	3,390	5.16	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,001	2,076	18,524	8.92	8
9	Activity Director	1,872	1,917	13,348	6.96	9
10	Activity Assistants	2,486	2,486	12,511	5.03	10
11	Social Service Workers	519	579	3,788	6.54	11
12	Dietician					12
13	Food Service Supervisor	2,341	2,419	23,339	9.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,249	10,344	63,356	6.12	15
16	Dishwashers					16
17	Maintenance Workers	3,220	3,414	24,512	7.18	17
18	Housekeepers	4,349	4,386	25,208	5.75	18
19	Laundry	3,690	3,808	25,717	6.75	19
20	Administrator	2,000	2,080	58,260	28.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,079	2,175	22,608	10.39	24
25	Vocational Instruction	439	439	8,612	19.62	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Utility Workers</u>	3,473	3,473	18,063	5.20	33
34	TOTAL (lines 1 - 33)	108,023	110,925	\$ 1,074,176 *	\$ 9.68	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	208	\$ 5,417	1-3	35
36	Medical Director	120	7,200	9-3	36
37	Medical Records Consultant	6	150	10-3	37
38	Nurse Consultant	162	6,210	10-3	38
39	Pharmacist Consultant	48	900	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				44
45	Social Service Consultant	51	2,910	12-3	45
46	Other(specify)				46
47	<u>ADMINISTRATIVE CONSULTANT</u>	408	10,906	17-3	47
48	<u>MEDICARE CONSULTANT</u>	8	2,603	10-3	48
49	TOTAL (lines 35 - 48)	1,011	\$ 36,296		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	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	SPRINKLER MAINT.	11/88	\$ 1,381	3 YR	\$	\$	\$	\$	\$	\$	\$	\$
2	PAINT & WALLPAPER	8/93	1,002	3 YR								
3	PAINT & WALLPAPER	8/94	3,809	3 YR								
4	PAINT & WALLPAPER	8/96-7/97	2,280	3 YR	760	380						
5	PAINT & WALLPAPER	8/97-7/98	2,415	3 YR	805	805	402					
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 10,887		\$ 1,565	\$ 1,185	\$ 402	\$	\$	\$	\$	\$

Facility Name & ID Number SUNRISE MANOR OF VIRDEN# 0025841

Report Period Beginning:

08/01/01

Ending:

07/31/02**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? NO
If YES, give association name and amount. _____
- (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? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 663 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 of Public Aid during this cost report period. \$ 54,203
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? YES 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 of Public Aid, 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V
PAGES 3 & 4

LINE 27 - OTHER

IL RT TAX	\$	3,080
SALES TAX		1,961
BAD DEBTS		6,243
LINE 27 - COLUMN 3	\$	<u>11,284</u>

COLUMN 5 - RECLASSIFICATION

		LINE #
TRANSFER FROM:		
MEDICARE SUPPLIES	\$	(541) 10
LABS		(207) 10
OXYGEN		(5,194) 10
MEDICARE DRUGS		(44,572) 10
PHYSICAL THERAPY		(126,190) 10A
SPEECH THERAPY		(8,542) 10A
OCCUPATIONAL THERAPY		<u>(71,978) 10A</u>
TRANSFER TO: ANCILLARY	\$	<u>257,224</u> 39
TRANSFER TO:		
NURSING CONSULTANT TRAVEL	\$	1,124 10
ADMINISTRATIVE CONSULTANT TRAVEL		<u>2,029</u> 17
TRANSFER FROM: TRAVEL	\$	<u>(3,153)</u> 24

SCHEDULE XIII
PAGE 15
NURSE AIDE TRAINING

OTHER FACILITIES TRAINED

JACKSONVILLE CONVALESCENT CENTER, INC
1517 W. WALNUT
JACKSONVILLE, IL 62650

MEADOW MANOR, INC.
800 MCADAM DRIVE
TAYLORVILLE, IL 62568

MENARD CONVALESCENT CENTER, INC.
120 W. ANTLE
PETERSBURG, IL 62675

D'ADRIAN CONVALESCENT CENTER, INC.
1373 D'ADRIAN PROFESSIONAL PARK
GODFREY, IL 62035

C.

SUNRISE MANOR OF VIRDEN

0025841

08/01/01 TO 07/31/02

PAGE 25

PAGE 2 QUESTION J

PAGE 23 QUESTION 12

FACILITY WAS LEASED 10/01/80 FROM NON-RELATED PARTY
FACILITY WAS PURCHASED 7/23/85

SALARY COSTS ALLOCATED TO DEPARTMEN
BASED UPON TIME CARDS

PAGE 13 SCHEDULE XI SECTION E
RECONCILIATION OF DEPRECIATION

LINE 83 \$ 53,734

NURSING HOME MANAGERS ALLOCATION 1,658

SCHEDULE V COLUMN 8 LINE 30 \$ 55,392

NT WORKED

SUNRISE MANOR OF VIRDEN

#

0025841

08/01/01 TO 07/31/02

PAGE 26

SCHEDULE XVII
PAGE 19 LINE 41

RECONCILIATION OF INCOME

LINE 41 NET INCOME	\$ 203,415
* ACCRUED MANAGEMENT FEE 7/01	(23,790)
* ACCRUED MANAGEMENT FEE 7/02	23,492
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	<u>(1,818)</u>
TAXABLE INCOME	\$ <u><u>201,299</u></u>

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS

