

Facility Name & ID Number SUNSHINE MANOR

30411 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

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	98	Skilled (SNF)	98	35,868	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	13,941	5,416	3,086	22,443	8
9	SNF/PED	0	0	0		9
10	ICF	0	0	0		10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	13,941	5,416	3,086	22,443	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.57%

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)

N/A - None

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 10/1/1985

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/1/1985 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 98 and days of care provided 3,086

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

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

Facility Name & ID Number

SUNSHINE MANOR

30411

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 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	104,001	4,062	7,908	115,971		115,971	(3,171)	112,800		1
2	Food Purchase		96,589		96,589		96,589	(362)	96,227		2
3	Housekeeping		6,264	84,644	90,908		90,908		90,908		3
4	Laundry		5,918	56,520	62,438		62,438		62,438		4
5	Heat and Other Utilities			70,323	70,323		70,323		70,323		5
6	Maintenance	28,806	4,690	31,895	65,391		65,391		65,391		6
7	Other (specify):*			1,758	1,758		1,758		1,758		7
8	TOTAL General Services	132,807	117,523	253,048	503,378		503,378	(3,533)	499,845		8
	B. Health Care and Programs										
9	Medical Director			10,998	10,998		10,998		10,998		9
10	Nursing and Medical Records	802,131	45,883	4,487	852,501		852,501		852,501		10
10a	Therapy		359	118,291	118,650		118,650		118,650		10a
11	Activities	39,529	2,556	2,759	44,844		44,844		44,844		11
12	Social Services	59,592	275	2,200	62,067		62,067		62,067		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	901,252	49,073	138,735	1,089,060		1,089,060		1,089,060		16
	C. General Administration										
17	Administrative	60,587			60,587		60,587		60,587		17
18	Directors Fees										18
19	Professional Services			207,423	207,423		207,423	1,243	208,666		19
20	Dues, Fees, Subscriptions & Promotions			36,373	36,373		36,373	(26,554)	9,819		20
21	Clerical & General Office Expenses	24,279	15,253	54,814	94,346		94,346	(37,961)	56,385		21
22	Employee Benefits & Payroll Taxes:			187,758	187,758		187,758	5,091	192,849		22
23	Inservice Training & Education			667	667		667	637	1,304		23
24	Travel and Seminar			1,970	1,970		1,970	2,627	4,597		24
25	Other Admin. Staff Transportation			5,366	5,366		5,366		5,366		25
26	Insurance-Prop.Liab.Malpractice			104,334	104,334		104,334		104,334		26
27	Other (specify):*										27
28	TOTAL General Administration	84,866	15,253	598,705	698,824		698,824	(54,917)	643,907		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,118,925	181,849	990,488	2,291,262		2,291,262	(58,450)	2,232,812		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			152,536	152,536		152,536	1,537	154,073			30
31	Amortization of Pre-Op. & Org.			16,742	16,742		16,742	(16,742)	(0)			31
32	Interest			464,737	464,737		464,737	(5,049)	459,688			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,805	1,805		1,805		1,805			35
36	Other (specify):*											36
37	TOTAL Ownership			635,820	635,820		635,819	(20,254)	615,565			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,927	30,422	151,349		151,349		151,349			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		120,927	84,224	205,151		205,151		205,151			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,118,925	302,776	1,710,532	3,132,233		3,132,232	(78,704)	3,053,528			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,685)	1		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				9
10	Interest and Other Investment Income	(5,049)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,070)	21		18
19	Entertainment				19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,581)	21		24
25	Fund Raising, Advertising and Promotional	(26,554)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(946)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (72,135)		\$	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	(16,742)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	10,173	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (6,569)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (78,704)		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			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SUNSHINE MANOR

ID# 30411

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MISC INCOME	\$ (1,635)	21	1
2	Raw Foods Rebate	(362)	2	2
3	Adjust Depreciation Expense to Schedule XI	1,537	30	3
4	Vendor income	(486)	1	4
5	0	0	0	5
6	0	0	0	6
7	0	0	0	7
8	0	0	0	8
9	0	0	0	9
10	0	0	0	10
11	0	0	0	11
12	0	0	0	12
13	0	0	0	13
14	0	0	0	14
15	0	0	0	15
16	0	0	0	16
17	0	0	0	17
18	0	0	0	18
19	0	0	0	19
20	0	0	0	20
21	0	0	0	21
22	0	0	0	22
23	0	0	0	23
24	0	0	0	24
25	0	0	0	25
26	0	0	0	26
27	0	0	0	27
28	0	0	0	28
29	0	0	0	29
30	0	0	0	30
31	0	0	0	31
32	0	0	0	32
33	0	0	0	33
34	0	0	0	34
35	0	0	0	35
36	0	0	0	36
37	0	0	0	37
38	0	0	0	38
39	0	0	0	39
40	0	0	0	40
41	0	0	0	41
42	0	0	0	42
43	0	0	0	43
44	0	0	0	44
45	0	0	0	45
46	0	0	0	46
47	0	0	0	47
48	0	0	0	48
49	Total	(946)		49

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
N/A		See Attached Listings				

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 Heat and Other Utilities	\$	Midamerica Care Foundation	100.00%	\$ 0	\$
2	V	19 Professional Services		Midamerica Care Foundation	100.00%	1,243	1,243
3	V	20 Due, Fees, Subscriptions & Promotions		Midamerica Care Foundation	100.00%	0	
4	V	21 Clerical & Other General Office		Midamerica Care Foundation	100.00%	575	575
5	V	22 Employee Benefits		Midamerica Care Foundation	100.00%	5,091	5,091
6	V	24 Travel & Seminar		Midamerica Care Foundation	100.00%	637	637
7	V	26 Insurance		Midamerica Care Foundation	100.00%	2,627	2,627
8	V	0	0	0	0.00%		
9	V	0	0	0	0.00%		
10	V	0	0	0	0.00%		
11	V	0	0	0	0.00%		
12	V	0	0	0	0.00%		
13	V	0	0	0	0.00%		
14	Total		\$			\$ 10,173	\$ * 10,173

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

Facility Name & ID Number SUNSHINE MANOR # 30411 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number SUNSHINE MANOR

30411

Report Period Beginning: 7/1/2003

Ending: 3/30/2004

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 MidAmerica Care Foundation
 Street Address 7611 State Line Rd Ste 301
 City / State / Zip Code Kansas City, MO 64114
 Phone Number (816-444-0900
 Fax Number) 0

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	eat and Other Utilities	Patient Days	241,015	8	0	22,443	\$	1
2	19	Professional Services	Patient Days	241,015	8	13,353	22,443	0	1,243
3	20	s, Subscriptions & Promotions	Patient Days	241,015	8	0	22,443	0	3
4	21	al & Other General Office	Patient Days	241,015	8	6,180	22,443	0	575
5	22	Employee Benefits	Patient Days	241,015	8	54,667	22,443	0	5,091
6	24	Travel & Seminar	Patient Days	241,015	8	6,843	22,443	0	637
7	26	Insurance	Patient Days	241,015	8	28,208	22,443	0	2,627
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					\$ 109,251	\$	\$	10,173

Facility Name & ID Number SUNSHINE MANOR # 30411 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Carlville Class 6(E) Bonds		X	Mortgage	VARIES	1/1/1985	\$ 3,700,000	3,860,485	11/1/2015	0.12	\$ 462,638	1
2	Macoupin County Treasurer		X	Past Due R/E Taxes	Varies	4/1/1991	74,958	23,326	4/1/2006	0.09	2,099	2
3					Varies							3
4												4
5												5
	Working Capital											
6	Interest Income		X								(5,049)	6
7	H/O Interest Income											7
8												8
9	TOTAL Facility Related						\$ 3,774,958	\$ 3,883,811			\$ 459,688	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,774,958	\$ 3,883,811			\$ 459,688	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2003 report.		\$	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.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td>8</td></tr> <tr><td>2000</td><td>9</td></tr> <tr><td>2001</td><td>10</td></tr> <tr><td>2002</td><td>11</td></tr> <tr><td>2003</td><td>12</td></tr> </table>	1999	8	2000	9	2001	10	2002	11	2003	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2003 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1999	8																										
2000	9																										
2001	10																										
2002	11																										
2003	12																										
FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2003 \$	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: 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSHINE MANOR COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 30411

CONTACT PERSON REGARDING THIS REPORT Ken Marx, BKD, LLP

TELEPHONE 314-231-5544 FAX #: 314-231-9731

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 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 2003.

	(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>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocation:

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 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 original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior BRICK & BLOCK Frame _____ 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 ground: (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: 406,451 2. Number of Years Over Which it is Being Amortized: Various
 3. Current Period Amortization: 16,742 4. Dates Incurred: Various

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	Facility	25,000		\$	1
2					2
3	TOTALS	25,000		\$	3

Facility Name & ID Number SUNSHINE MANOR

30411

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

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	98	85	75	\$ 2603743	\$ 86,791	30	\$ 86,791	\$	\$ 1,620,106	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Improvements 1986		86	200,948	6,929	29	6,929		123,899	9
10	Improvements 1987		87	2,931		15			2,931	10
11	Improvements 1990		90	7,589		12			7,589	11
12	Improvements 1991		91	87,447		7			87,447	12
13	Improvements 1992		92	9,887		7			9,887	13
14	Improvements 1993		93	32,583		7			32,583	14
15	Improvements 1994		94	25,815	1,138	10	1,138		25,815	15
16	Improvements 1995		95	38,667	3,867	10	3,867		29,861	16
17	Improvements 1996		96	34,955	3,496	10	3,496		24,745	17
18	Kohler Hopper		97	800	27	30	27		198	18
19	3-Ton Air Conditioning Unit		97	2,903	97	30	97		710	19
20	Handrails		97	3,967	264	15	264		1,895	20
21	Fire Door		97	620	41	15	41		296	21
22	Draperies		97	1,836	122	15	122		866	22
23	Windows for Dining Room		96	2,049	68	30	68		523	23
24	Windows for Dining Room		96	4,163	139	30	139		1,064	24
25	PT & Activity Model		97	6,500	217	30	217		1,607	25
26	Carpeting for Offices		97	2,442	244	10	244		1,811	26
27	Tiling Dining and Living Rooms		97	9,900	990	10	990		7,095	27
28	Garage		97	7,390	246	30	246		1,765	28
29	Wall Paper		97	3,556	119	30	119		840	29
30	Fire Wall		97	1,446	72	20	72		506	30
31	Wall Paper		98	5,357	357	15	357		2,083	31
32	Ceiling Tile		99	1,396	93	15	93		475	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 SUNSHINE MANOR

30411

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

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	99	\$ 1,840	\$ 123	15	\$ 123	\$	\$ 624		37
38	99	3,221	215	15	215		1,074		38
39	99	1,150	77	15	77		384		39
40	99	3,620	241	15	241		1,166		40
41	99	5,559	556	10	556		2,687		41
42	98	1,607	161	10	161		978		42
43	97	1,118	160	7	160		1,118		43
44	2000	2,060	172	12	172		687		44
45	2002	1,800	225	8	225		619		45
46	2002	3,151	394	8	394		1,149		46
47	2002	650	130	5	130		347		47
48	2002	2,100	105	20	105		289		48
49	2002	1,543	309	5	309		798		49
50	2002	3,432	343	10	343		858		50
51	2002	727	73	10	73		176		51
52	2002	9,990	500	20	500		1,208		52
53	2002	2,180	218	10	218		563		53
54	2002	5,879	392	15	392		1,404		54
55	2002	3,815	382	10	382		954		55
56	2002	67,913	6,791	10	6,791		14,714		56
57	2003	1,095	110	10	110		220		57
58	2003	21,184	1,412	15	1,412		2,824		58
59	2003	7,154	715	10	715		1,430		59
60	2003	24,533	1,227	20	1,227		2,454		60
61	2003	5,600	560	10	560		1,120		61
62									62
63	(DON'T ENTER BELOW THIS LINE)								
64	Total (This Page)								
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,281,811	\$ 120,908		\$ 120,908	\$	\$ 2,026,442	70

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

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 3,281,811	\$ 120,908		\$ 120,908		\$ 2,026,442		1
2	Interior Painting	2003 \$ 46312	\$ 9262	5	\$ 9262		\$ 18524		2
3	Nurse Call System	2003 2850	285	10	285		285		3
4	Sprinkler system	2003 1711	68	25	68		68		4
5	Roof	2004 47743	2387	20	2387		2387		5
6									6
7									7
8									8
9									9
10	2004 Depreciation Adjustment		-1537			1537			10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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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)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

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		
1	Totals from Page 12B, Carried Forward	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		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
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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)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

Facility Name & ID Number SUNSHINE MANOR

30411

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		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	TOTAL (lines 1 thru 33)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		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
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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)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

Facility Name & ID Number SUNSHINE MANOR

30411

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,380,427	\$ 131,373		\$ 132,910	\$ 1,537	\$ 2,047,706		34

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

XI. OWNERSHIP COSTS (continued)

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	\$ 347,223	\$ 20,163	\$ 20,163	\$		\$ 247,522	71
72	Current Year Purchases	14,780	1,000	1,000			1,000	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 362,003	\$ 21,163	\$ 21,163	\$		\$ 248,522	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,742,430	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,536	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 154,073	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,537	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,296,228	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: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</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: \$ 1,805 Description: See attached detail for rental expense
 (Attach a schedule detailing the breakdown of movable equipment)

* 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.

C. Vehicle Rental (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide 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 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.

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

- (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	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	10a, 3	hrs	\$	1,035	\$	53,315	\$	0	1,035	\$	53,315	1	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		141		9,830		0	141		9,830	2	
3	Licensed Recreational Therapist		hrs		0		0		0				3	
4	Licensed Physical Therapist	10a, 3	hrs		1,292		55,147		142	1,292		55,289	4	
5	Physician Care	0	visits		0		0		0				5	
6	Dental Care	0	visits		0		0		0				6	
7	Work Related Program	0	hrs		0		0		0				7	
8	Habilitation	0	hrs		0		0		0				8	
9	Pharmacy		# of prescripts		0		0		0				9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	0	hrs		0		0		0				10	
11	Academic Education	0	hrs		0		0		0				11	
12	Exceptional Care Program	0			0		0		0				12	
13	Other (specify):	0			0		0		0				13	
14	TOTAL			\$	2,468	\$	118,292	\$	142	2,468	\$	118,434	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

Page 17

Facility Name & ID Number SUNSHINE MANOR

30411

Report Period Beginning: 7/1/2003

Ending:

6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2004

(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	\$ 247,170	\$	1
2	Cash-Patient Deposits	10,915		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	234,927		3
4	Supply Inventory (priced at)	10,067		4
5	Short-Term Investments			5
6	Prepaid Insurance	0		6
7	Other Prepaid Expenses	8,698		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 511,777	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	10,055		12
13	Land			13
14	Buildings, at Historical Cost	3,332,915		14
15	Leasehold Improvements, at Historical Cost	14,501		15
16	Equipment, at Historical Cost	396,651		16
17	Accumulated Depreciation (book methods)	(2,271,019)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	406,451		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(258,698)		20
21	Restricted Funds	5,548		21
22	Other Long-Term Assets (sp)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,636,404	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,148,181	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 85,614	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,915		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,046		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,860		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,652,764		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Other accrued expenses	2,448		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,826,647	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	3,860,485		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)	\$ 3,860,485	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,687,132	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,538,951)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,148,181	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,998,349)	1
2	Restatements (describe):		2
3	Restatements of Prior Year to allow rollforward	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,998,350)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(540,601)	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)	0	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (540,601)	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)	\$ (6,538,951)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number SUNSHINE MANOR

30411

Report Period Beginning: 7/1/2003

Page 19
Ending: 6/30/2004

VII. 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	\$ 2,254,728	1
2	Discounts and Allowances for all Levels	(192,334)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,062,394	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,985	6
7	Oxygen	3,692	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 271,677	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,171	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	187,347	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,320	19
20	Radiology and X-Ray		20
21	Other Medical Services	69,429	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 277,267	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,049	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,049	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	(24,755)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (24,755)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,591,632	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	503,378	31
32	Health Care	1,089,060	32
33	General Administration	698,824	33
B. Capital Expense			
34	Ownership	635,820	34
C. Ancillary Expense			
35	Special Cost Centers	151,349	35
36	Provider Participation Fee	53,802	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,132,233	40
41	Income before Income Taxes (line 30 minus line 40)**	(540,601)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (540,601)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Pending 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 SUNSHINE MANOR

30411

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

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	6,340	6,404	\$ 181,019	\$ 28.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,499	4,540	85,920	18.93	3
4	Licensed Practical Nurses	9,385	9,474	148,915	15.72	4
5	Nurse Aides & Orderlies	38,790	39,055	360,277	9.22	5
6	Nurse Aide Trainees	2,152	2,197	19,766	9.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,226	3,672	39,529	10.76	10
11	Social Service Workers	4,470	4,526	59,592	13.17	11
12	Dietician	13,303	13,464	104,001	7.72	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,941	1,965	28,806	14.66	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,936	2,016	60,587	30.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,605	3,661	24,279	6.63	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	829	829	6,234	7.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,476	91,803	\$ 1,118,925 *	\$ 12.19	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	92	\$ 7,706	1, 3	35
36	Medical Director	74	10,998	9, 3	36
37	Medical Records Consultant	22	720	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	77	3,767	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	45	2,200	11, 3	44
45	Social Service Consultant	56	2,200	12, 3	45
46	Other(specify)	0			46
47					47
48					48
49	TOTAL (lines 35 - 48)	366	\$ 27,590		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

Facility Name & ID Number SUNSHINE MANOR

30411

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

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. 7722 - Illinois Health Care Assoc.
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,008 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. N/A
- (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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,802
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 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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,685
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BKD, LLP KC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. In progress
- (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? YES
Attach invoices and a summary of services for all architect and appraisal fees.