

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH License ID Number:** 0011643

**Facility Name:** SUNSET HOME

**Address:** 418 WASHINGTON STREET QUINCY 62301  
 Number City Zip Code

**County:** ADAMS

**Telephone Number:** 217-223-2636 **Fax #** 217-223-9867

**HFS ID Number:** 370661224-001

**Date of Initial License for Current Owners:** NOT AVAIALBLE

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501c(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

**In the event there are further questions about this report, please contact:**  
**Name:** KELLEY HATFIELD **Telephone Number:** 217-223-2636 EXT 311

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/06 to 09/30/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Type or Print Name) CHRIS HOPSON

(Title) CEO/ADMINISTRATOR

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Print Name and Title) TIMOTHY WIEWEL  
PROPRETOR

(Firm Name & Address) TIMOTHY J WIEWEL CPA  
PO BOX 1028 QUINCY IL 62306

(Telephone) 217-223-2245 Fax # 217-223-7580

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SUNSET HOME

# 0011643 Report Period Beginning: 10/1/06 Ending: 09/30/07

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	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,480	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,315	5
6		ICF/DD 16 or Less			6
7	202	TOTALS	202	73,730	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13	67	4,594	4,674	8
9	SNF/PED					9
10	ICF	26,730	19,751		46,481	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,743	19,818	4,594	51,155	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.38%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

INDIVIDUAL LIVING UNITS, SENIOR APARTMENTS

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     /    /    

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

YES  Date     /    /     NO

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

YES  NO  If YES, enter number of beds certified 19 and days of care provided 4,594

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:     /    /     Fiscal Year:     /    /    

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/06 Ending: 09/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	549,921	34,830	9,335	594,086		594,086	594,086			1
2	Food Purchase		222,487		222,487		222,487	222,487			2
3	Housekeeping	207,099	56,526		263,625		263,625	263,625			3
4	Laundry	42,945	3,026	153,139	199,110		199,110	199,110			4
5	Heat and Other Utilities			428,118	428,118		428,118	428,118			5
6	Maintenance	181,027	50,737	53,116	284,880	(1,040)	283,840	(14,200)	269,640		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>980,992</b>	<b>367,606</b>	<b>643,708</b>	<b>1,992,306</b>	<b>(1,040)</b>	<b>1,991,266</b>	<b>(14,200)</b>	<b>1,977,066</b>		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	3,589,479	191,965	49,740	3,831,184		3,831,184	3,831,184			10
10a	Therapy		1,961	279,435	281,396		281,396	281,396			10a
11	Activities	125,583	3,783	4,040	133,406		133,406	133,406			11
12	Social Services	107,108	230	17,644	124,982		124,982	124,982			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,822,170</b>	<b>197,939</b>	<b>350,859</b>	<b>4,370,968</b>		<b>4,370,968</b>	<b>4,370,968</b>			16
	<b>C. General Administration</b>										
17	Administrative	88,247			88,247		88,247	88,247			17
18	Directors Fees										18
19	Professional Services			51,256	51,256		51,256	(5,952)	45,304		19
20	Dues, Fees, Subscriptions & Promotions			20,813	20,813		20,813	20,813			20
21	Clerical & General Office Expenses	261,874	5,574	88,451	355,899		355,899	(275)	355,624		21
22	Employee Benefits & Payroll Taxes			1,243,488	1,243,488	(6,999)	1,236,489		1,236,489		22
23	Inservice Training & Education			2,980	2,980		2,980	2,980			23
24	Travel and Seminar			7,500	7,500	(1,412)	6,088		6,088		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			148,570	148,570		148,570		148,570		26
27	Other (specify):* <b>BAD DEBT</b>			27,038	27,038		27,038	(27,038)			27
28	<b>TOTAL General Administration</b>	<b>350,121</b>	<b>5,574</b>	<b>1,590,096</b>	<b>1,945,791</b>	<b>(8,411)</b>	<b>1,937,380</b>	<b>(33,265)</b>	<b>1,904,115</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,153,283</b>	<b>571,119</b>	<b>2,584,663</b>	<b>8,309,065</b>	<b>(9,451)</b>	<b>8,299,614</b>	<b>(47,465)</b>	<b>8,252,149</b>		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 SUNSET HOME #0011643 Report Period Beginning: 10/1/06 Ending: 09/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			545,232	545,232	(129,907)	415,325		415,325		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			276,047	276,047	(126,543)	149,504	(764)	148,740		32
33	Real Estate Taxes					1,040	1,040		1,040		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			821,279	821,279	(255,410)	565,869	(764)	565,105		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		122,253		122,253		122,253		122,253		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			93,623	93,623		93,623		93,623		42
43	Other (specify):*			458,182	458,182	264,861	723,043	(723,043)			43
44	<b>TOTAL Special Cost Centers</b>		122,253	551,805	674,058	264,861	938,919	(723,043)	215,876		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,153,283	693,372	3,957,747	9,804,402		9,804,402	(771,272)	9,033,130		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 SUNSET HOME

# 0011643

Report Period Beginning: 10/1/06

Ending: 09/30/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,400)	6		5
6	Rented Facility Space	(1,800)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(764)	32		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	(275)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,952)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,038)	27		24
25	Fund Raising, Advertising and Promotional	(67,832)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (116,061)		\$	30

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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (116,061)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

SUNSET HOME

ID# 0011643  
 Report Period Beginning: 10/1/06  
 Ending: 09/30/07

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	VILLA	(114,289)	43	2
3	SUNSET APARTMENTS	(540,922)	43	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	<b>Total</b>	(655,211)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SUNSET HOME

# 0011643

Report Period Beginning:

10/1/06

Ending:

09/30/07

## 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)	
	<b>A. General Services</b>													
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	(14,200)	0	0	0	0	0	0	0	0	0	0	(14,200)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(14,200)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,200)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,952)	0	0	0	0	0	0	0	0	0	0	(5,952)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(275)	0	0	0	0	0	0	0	0	0	0	(275)	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	0	0	0	0	0	0	0	0	0	0	0	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):*	(27,038)	0	0	0	0	0	0	0	0	0	0	(27,038)	27
28	<b>TOTAL General Administration</b>	<b>(33,265)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(33,265)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(47,465)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(47,465)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number SUNSET HOME

# 0011643 Report Period Beginning:

10/1/06 Ending:

Summary B

09/30/07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(764)	0	0	0	0	0	0	0	0	0	0	(764)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(764)</b>	<b>0</b>	<b>(764)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(723,043)	0	0	0	0	0	0	0	0	0	0	(723,043)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(723,043)</b>	<b>0</b>	<b>(723,043)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(771,272)</b>	<b>0</b>	<b>(771,272)</b>	<b>45</b>									

Facility Name & ID Number SUNSET HOME

# 0011643

Report Period Beginning:

10/1/06

Ending:

09/30/07

**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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

SUNSET HOME

#

0011643

Report Period Beginning:

10/1/06

Ending:

09/30/07

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number SUNSET HOME

# 0011643 Report Period Beginning: 10/1/06

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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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	MERCANTILE		X	RENOVATION 1,2,4		12/19/03	\$ 2,150,000	\$ 2,022,828	12/19/28	0.0450	\$ 99,681	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MEERCANTILE		X	LINE OF CREDIT OPERATIONS		12/21/97	1,000,000	990,859	12/21/07	0.0825	49,059	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 3,150,000	\$ 3,013,687			\$ 148,740	9								
<b>B. Non-Facility Related*</b>																				
10	MERCANTILE		X	APARTMENTS PERM LOAN		12/19/03	2,850,000	2,721,523	12/19/28	0.0450	126,543	10								
11	GIFT ANNUITIES		X	NONE							764	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$ 2,850,000	\$ 2,721,523			\$ 127,307	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 6,000,000	\$ 5,735,210			\$ 276,047	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 **SUNSET HOME**

# **0011643** Report Period Beginning: **10/1/06**

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

**B. Real Estate Taxes**

<p><b>Important</b>, 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 2006 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 2007 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	2002	567	8
	2003	574	9
	2004	344	10
	2005	502	11
	2006		12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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 Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT KELLEY HATFIELD

TELEPHONE 217-223-2636 EXT 311 FAX #: 217-223-9867

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>23-2-0917-000-00</u>	<u>VACANT LOT</u>	\$ <u>46.31</u>	\$ <u>46.31</u>
2. <u>23-2-0973-000-00</u>	<u>VACANT LOT</u>	\$ <u>21.92</u>	\$ <u>21.92</u>
3. <u>23-2-0926-000-00</u>	<u>VACANT LOT</u>	\$ <u>91.55</u>	\$ <u>91.55</u>
4. <u>23-2-0972-000-00</u>	<u>VACANT LOT</u>	\$ <u>21.92</u>	\$ <u>21.92</u>
5. <u>23-2-0975-000-00</u>	<u>VACANT LOT</u>	\$ <u>65.04</u>	\$ <u>65.04</u>
6. <u>23-2-0979-000-00</u>	<u>VACANT LOT</u>	\$ <u>41.00</u>	\$ <u>41.00</u>
7. <u>23-2-0971-000-00</u>	<u>VACANT LOT</u>	\$ <u>66.10</u>	\$ <u>66.10</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>353.84</u>	\$ <u>353.84</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 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number SUNSET HOME

# 0011643 Report Period Beginning:

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 144,818 B. General Construction Type: Exterior BRICK Frame STEEL-FIREPROOF Number of Stories 4

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

VILLA APARTMENTS 16-2 BEDROOM UNITS 16,000 SQ FT

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>FACILITY</u>	<u>199,487</u>		<u>\$ 102,419</u>	<u>1</u>
2	<u>PARKING LOT ADDITIONAL</u>	<u>15,000</u>	<u>1996-97</u>	<u>86,288</u>	<u>2</u>
3	<b>TOTALS</b>	<b>214,487</b>		<b>\$ 188,707</b>	<b>3</b>

Facility Name & ID Number SUNSET HOME

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**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1958	1958	\$ 354,000	\$ 7,080	50	\$ 7,080		\$ 350,460	4
5	71		1971	1971	1,218,562	24,371	50	24,371		877,336	5
6	49		1972	1972	472,577	9,452	50	9,452		337,899	6
7	5		1987	1987	68,497	3,138	20	3,138		68,497	7
8	43		2001	2001	2,500,281	83,343	30	83,343		500,056	8
		<b>Improvement Type**</b>									
9		BUILDINGS & IMPROVEMENTS		1958	12,000		10			12,000	9
10		BUILDINGS & IMPROVEMENTS		1972	51,124	1,023	50	1,023		35,794	10
11		BUILDINGS & IMPROVEMENTS		1977	14,179		20			14,179	11
12		BUILDINGS & IMPROVEMENTS		1978	442,103	8,842	50	8,842		260,955	12
13		BUILDINGS & IMPROVEMENTS		1979	13,639	273	50	273		7,777	13
14		BUILDINGS & IMPROVEMENTS		1980	771		20			771	14
15		BUILDINGS & IMPROVEMENTS		1981	3,742		10			3,742	15
16		BUILDINGS & IMPROVEMENTS		1982	13,900		10			13,900	16
17		BUILDINGS & IMPROVEMENTS		1983	14,951		20			14,951	17
18		BUILDINGS & IMPROVEMENTS		1985	272,013	6,800	40	6,800		151,751	18
19		BUILDINGS & IMPROVEMENTS		1987	321,886	6,003	10-20	6,003		321,885	19
20		BUILDINGS & IMPROVEMENTS		1988	36,315	239	10-20	239		36,218	20
21		BUILDINGS & IMPROVEMENTS		1989	99,114	3,971	10-20	3,971		95,061	21
22		BUILDINGS & IMPROVEMENTS		1990	36,949	1,847	20	1,847		31,633	22
23		BUILDINGS & IMPROVEMENTS		1992	11,222	156	10-20	156		10,489	23
24		BUILDINGS & IMPROVEMENTS		1993	31,474	1,151	5-20	1,151		24,703	24
25		BUILDINGS & IMPROVEMENTS		1994	9,466	382	5-20	382		6,984	25
26		BUILDINGS & IMPROVEMENTS		1995	99,649	5,321	5-15	5,321		86,861	26
27		BUILDINGS & IMPROVEMENTS		1996	25,111	1,256	20	1,256		13,995	27
28		BUILDINGS & IMPROVEMENTS		1997	356,451	17,115	5-20	17,115		197,439	28
29		BUILDINGS & IMPROVEMENTS		1998	107,004	5,298	5-20	5,298		53,490	29
30		BUILDINGS & IMPROVEMENTS		1999	1,696	170	10	170		1,442	30
31		BUILDINGS & IMPROVEMENTS		2000	30,811	1,540	20	1,540		10,424	31
32		BUILDINGS & IMPROVEMENTS		2001	24,121	2,230	10-20	2,230		13,285	32
33		BUILDINGS & IMPROVEMENTS		2002	48,990	4,460	10-20	4,460		24,094	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

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**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	3 DOORS - REHAB OFFICE CARE PLAN	2004	\$ 1,628	\$ 163	10	\$ 163	\$	\$ 570	37
38	PLUMBING FIXTURES ROOM 364	2004	8,800	440	20	440		1,540	38
39	CARPET DINING ROOM	2004	1,464	146	5	146		586	39
40	2 12"10 OVERHEAD DOORS	2004	4,150	415	10	415		1,245	40
41	RENOVATION 3RD FLOOR SHOWER ROOM	2006	56,337	2,817	20	2,817		4,225	41
42	RENOVATION 1ST 2ND 4TH FLOOR WEST	2007	2,737,487	54,750	25	54,750		54,750	42
43	RAMPS AND RAILS	2007	2,939	98	15	98		98	43
44	WALLGUARD	2007	5,808	194	15	194		194	44
45	DRAPES AND HARDWARE 1ST 2ND 4TH	2007	42,347	2,117	10	2,117		2,117	45
46	CONCRETE WORK	2007	13,500	450	15	450		450	46
47									47
48	ASSETS DISPOSED OF DURING YEAR BUILDING IMPROVEMENTS			2,748		2,748			48
49	ASSETS DISPOSED OF DURING YEAR FIXED EQUIPMENT			357		357			49
50	FIXED EQUIPMENT	1971	814,827		25			814,827	50
51	FIXED EQUIPMENT	1972	253,064		25			253,063	51
52	FIXED EQUIPMENT	1978	280,726		25			280,726	52
53	FIXED EQUIPMENT	1979	13,938		10			13,938	53
54	FIXED EQUIPMENT	1984	23,531		10			23,531	54
55	FIXED EQUIPMENT	1985	117,689		5-20			117,687	55
56	FIXED EQUIPMENT	1986	13,909		10-15			13,908	56
57	FIXED EQUIPMENT	1987	12,320	294	10-20	294		12,320	57
58	FIXED EQUIPMENT	1988	8,162	241	10-20	241		8,085	58
59	FIXED EQUIPMENT	1989	4,670		15			4,670	59
60	FIXED EQUIPMENT	1993	259,307	11,891	10-20	11,891		191,926	60
61	FIXED EQUIPMENT	1995	188,017	9,549	10-20	9,549		117,634	61
62	FIXED EQUIPMENT	1996	10,809	415	10-15	415		10,503	62
63	FIXED EQUIPMENT	1997	35,461	1,812	15-20	1,812		18,715	63
64	FIXED EQUIPMENT	1998	173,001	8,865	15-20	8,865		84,136	64
65	FIXED EQUIPMENT	1999	8,744	526	15-20	526		4,117	65
66	FIXED EQUIPMENT	2000	272,461	14,155	10-20	14,155		102,027	66
67	FIXED EQUIPMENT	2001	40,619	2,424	10-20	2,424		14,274	67
68	FIXED EQUIPMENT	2002	81,604	5,504	10-20	5,504		27,906	68
69	FIXED EQUIPMENT	2003	105,075	6,172	15-20	6,172		25,694	69
70	TOTAL (lines 4 thru 69)		\$ 12,284,992	\$ 322,004		\$ 322,004	\$	\$ 5,783,533	70

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

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## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 12,284,992	\$ 322,004		\$ 322,004	\$	\$ 5,783,533	1
2	INSTALL 18 CEILING RADIATION FIRE DAMPERS	2004	3,840	256	15	256		896	2
3	REPLACE COPPER LINES & VALVES TO STORAGE TANK	2004	6,597	264	25	264		924	3
4	REPLACE CRACKED SECTION BOILER #3	2004	4,317	288	15	288		1,007	4
5	HANDRAIL OUTSIDE RAMP TO DINING ROOM	2004	14,780	985	15	985		3,449	5
6	BOILER PLANT PROBLEMS	2004	5,000	333	15	333		1,167	6
7	HOT WATER RHEEM GBCP 12 BOILER	2004	6,540	436	15	436		1,526	7
8	INSTALL 2 SPRAGUE 1 1/4" GAS CONTROL REGULATORS	2004	2,043	136	15	136		477	8
9	PROJECT 2 3 4 FLOORS SMOKE DETECTORS	2004	1,946	130	15	130		454	9
10	REPLACE CYLINDER KITCHEN ELEVATOR	2004	18,600	930	20	930		3,255	10
11	REPLACE EXV VALVE EAST CHILLER	2004	1,526	102	15	102		356	11
12	REPAIRS TO BOILERS #1 & #2	2004	3,365	224	15	224		785	12
13	1 3POLE 600V 225A CIRCUIT BREAKER	2004	1,133	57	20	57		142	13
14	CHILLER REPLACEMENT WEST OF MAIN DR	2004	72,429	4,829	15	4,829		12,072	14
15	INSTALL NEW 4" RPZ VALVE SPRINKLER SYSTEM	2005	3,556	142	25	142		356	15
16	REPAIR BOILER #2	2005	9,217	614	15	614		1,536	16
17	NEW DAMPER WEST PENTHOUSE	2005	4,556	304	15	304		759	17
18	NEW 480 WATT DISCONNECT	2005	6,268	313	20	313		627	18
19	BUSBOY DISPOSER	2005	1,708	114	15	114		285	19
20	WANDERGUARD	2005	4,048	270	15	270		675	20
21	INSTALLED NEW CARD PHONE SYSTEM	2005	1,192	119	10	119		298	21
22	BOILER #3 SECTION REPLACEMENT	2005	5,289	353	15	353		2,116	22
23	NEW BOILER W/GASKETS	2005	2,588	173	15	173		1,035	23
24	RELOCATE DOOR ALARM SYSTEM	2005	12,898	860	15	860		5,159	24
25	SUPRESSION SYSTEM MAIN KITCHEN	2007	4,827	97	25	97		97	25
26	OUTDOOR EMERGENCY LIGHTING	2007	9,680	323	15	323		323	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,492,935	\$ 334,656		\$ 334,656	\$	\$ 5,823,309	34

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

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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		\$ 12,492,935	\$ 334,656		\$ 334,656	\$	\$ 5,823,309	1
2	LAND IMPROVEMENTS	1975	2,807		25			2,807	2
3	LAND IMPROVEMENTS	1978	495		10			495	3
4	LAND IMPROVEMENTS	1979	6,425		10			6,425	4
5	LAND IMPROVEMENTS	1992	56,865		10			56,865	5
6	LAND IMPROVEMENTS	1995	18,601	905	12	905		18,601	6
7	LAND IMPROVEMENTS	1997	4,800	192	25	192		2,016	7
8	LAND IMPROVEMENTS	1999	44,219	3,685	12	3,685		31,323	8
9	LAND IMPROVEMENTS	2000	17,559	707	10-25	707		12,050	9
10	LAND IMPROVEMENTS	2001	1,952	195	10	195		1,268	10
11	LAND IMPROVEMENTS	2003	8,404	560	15	560		2,520	11
12	SIDEWALK	2004	3,450	230	15	230		805	12
13	SEEDING & IMPROVEMENTS SO 4TH	2006	20,477	2,048	10	2,048		3,072	13
14									14
15									15
16									16
17									17
18	ROUNDING		(6)	(3)		(3)			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)		\$ 12,678,983	\$ 343,175		\$ 343,175	\$	\$ 5,961,556	34

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/06 Ending: 09/30/07

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	\$ 453,800	\$ 44,723	\$ 44,723	\$		\$ 282,460	71
72	Current Year Purchases	161,040	6,944	6,944			6,944	72
73	Fully Depreciated Assets	279,366	2,201	2,201			279,366	73
74								74
75	TOTALS	\$ 894,206	\$ 53,868	\$ 53,868	\$		\$ 568,770	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	MAINTENANCE	97 3/4 TON GMC & PLOW	1997	\$ 23,521	\$	\$	\$	4-5	\$ 23,521	76
77	RESIDENT TRANSPORT	2001 E-450 FORD BUS	2001	56,836	5,684	5,684		5	56,836	77
78	RESIDENT TRANSPORT	1994 FOR VAN	1995	36,216				4	36,216	78
79	RESIDENT TRANSPORT	2005 TRANSPORT BUS	2005	50,391	12,598	12,598		4	31,495	79
80	TOTALS			\$ 166,964	\$ 18,282	\$ 18,282	\$		\$ 148,068	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)		\$ 13,928,860	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 415,325	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 415,325	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 6,678,394	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	VILLA INDEP UNITS	\$ 1,729,678	\$ 48,276	\$ 805,709	86
87	SUNSET APARTMENTS	2,777,195	81,631	320,505	87
88					88
89					89
90					90
91	TOTALS	\$ 4,506,873	\$ 129,907	\$ 1,126,214	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \_\_\_\_\_

(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	<b>TOTAL</b>		\$ _____	\$ _____	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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs 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><u>COMMUNITY COLLEGE TRAINS AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 114,719	\$		\$ 114,719	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			11,123			11,123	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			153,593	1,961		155,554	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts			122,253			122,253	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 401,688	\$ 1,961		\$ 403,649	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SUNSET HOME# 0011643Report Period Beginning: 10/1/06

Ending:

09/30/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 89,028	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	891,442		3
4	Supply Inventory (priced at <u>COST</u> )	74,819		4
5	Short-Term Investments	13,035		5
6	Prepaid Insurance	79,963		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,148,287	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,707		13
14	Buildings, at Historical Cost	12,678,983		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,061,170		16
17	Accumulated Depreciation (book methods)	(6,678,394)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,135,015		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>LIST ATTACHED</u>	5,729,852		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 15,115,333	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 16,263,620	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 603,323	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	444,423		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	59,762		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>SUNSET APARTMENTS</u>	72,640		36
37	<u>HEALTH CLAIMS PAYABLE</u>	108,557		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,288,705	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,013,687		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>N/P SUNSET APARTMENTS</u>	2,721,523		43
44	<u>REF FEES DEFERRED REVENUE</u>	49,519		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,784,729	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,073,434	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,190,186	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 16,263,620	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>10,600,026</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>10,600,026</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,409,840)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,409,840)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>9,190,186</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number SUNSET HOME# 0011643Report Period Beginning: 10/1/06Ending: 09/30/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,931,370	1
2	Discounts and Allowances for all Levels	(1,677,800)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,253,570	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,800	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,800	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	188,059	24
25	Interest and Other Investment Income***	88,372	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 276,431	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>CHANGE IN VALUE SPLIT INTEREST AGREEMENT</b>	85,080	28
28a	<b>SEE ATTACHED</b>	777,681	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 862,761	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,394,562	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,991,266	31
32	Health Care	4,370,968	32
33	General Administration	1,937,380	33
<b>B. Capital Expense</b>			
34	Ownership	565,869	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	122,253	35
36	Provider Participation Fee	93,623	36
<b>D. Other Expenses (specify):</b>			
37	<b>FUND DEVELOPMENT</b>	67,832	37
38	<b>SUNSET APARTMENTS</b>	540,922	38
39	<b>VILLA INDEPENDENT UNITS</b>	114,289	39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,804,402	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,409,840)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,409,840)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

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

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

Facility Name & ID Number **SUNSET HOME**

# **0011643**

Report Period Beginning:

10/1/06

Ending:

09/30/07

**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	1,869	2,087	\$ 60,785	\$ 29.13	1
2	Assistant Director of Nursing	1,982	2,087	52,167	25.00	2
3	Registered Nurses	28,035	30,247	588,897	19.47	3
4	Licensed Practical Nurses	72,157	78,110	1,178,188	15.08	4
5	CNAs & Orderlies	144,639	156,521	1,626,475	10.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,926	2,100	26,192	12.47	9
10	Activity Assistants	10,810	11,627	99,392	8.55	10
11	Social Service Workers	5,457	6,125	80,916	13.21	11
12	Dietician					12
13	Food Service Supervisor	1,750	2,007	37,092	18.48	13
14	Head Cook	1,763	2,006	30,988	15.45	14
15	Cook Helpers/Assistants	44,479	48,461	437,221	9.02	15
16	Dishwashers	3,663	4,261	43,384	10.18	16
17	Maintenance Workers	9,474	10,435	132,905	12.74	17
18	Housekeepers	22,318	24,570	207,098	8.43	18
19	Laundry	3,744	4,183	42,945	10.27	19
20	Administrator	1,779	2,086	88,247	42.30	20
21	Assistant Administrator					21
22	Other Administrative	4,957	5,490	110,162	20.07	22
23	Office Manager					23
24	Clerical	10,424	11,654	151,713	13.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,992	2,180	22,227	10.20	31
32	Other Health Care(specify)	7,962	8,554	88,167	10.31	32
33	Other(specify)	1,850	2,087	48,122	23.06	33
34	TOTAL (lines 1 - 33)	383,030	416,878	\$ 5,153,283 *	\$ 12.36	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		\$ 8,239	1-3	35
36	Medical Director		3,600	10-3	36
37	Medical Records Consultant		1,620	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,804	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		1,777	11-3	44
45	Social Service Consultant		1,777	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,817		49

**C. CONTRACT NURSES**

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





**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. LIFE SERVICES NETWORK \$8,083
- (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? YES If YES, what is the capacity? 171
- (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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,664 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 93,623  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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? YES Indicate the amount. \$ 30,000
- (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? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: BENNETT & MIDDENDORF LTD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES 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 \$5,000, 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.