



Facility Name & ID Number Sunset Rehabilitation & Hlth C

# 0046094 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	25	Skilled (SNF)	25	9,125	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	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			3,450	3,450	8
9	SNF/PED					9
10	ICF	26,019	9,391		35,410	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,019	9,391	3,450	38,860	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.58%

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

None (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)

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

Non-allowable costs have been eliminated in Schedule V, Column 7

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 08/01/90

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

YES

Date 08/01/90

NO

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

YES

NO

If YES, enter number of beds certified 25 and days of care provided 3,450

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES  NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Sunset Rehabilitation & Hlth C # 0046094 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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	154,974	16,865	2,573	174,412		174,412	3,252	177,664		1
2	Food Purchase		222,509		222,509		222,509	(41,288)	181,221		2
3	Housekeeping	186,548	20,608		207,156		207,156	37	207,193		3
4	Laundry	42,697	16,864		59,561		59,561	2	59,563		4
5	Heat and Other Utilities			113,894	113,894		113,894	555	114,449		5
6	Maintenance	37,219	20,213	25,265	82,697		82,697	4,284	86,981		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,484	1,484		7
8	<b>TOTAL General Services</b>	421,438	297,059	141,732	860,229		860,229	(31,674)	828,555		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			23,587	23,587		23,587		23,587		9
10	Nursing and Medical Records	1,503,510	97,648	4,201	1,605,359		1,605,359	6,414	1,611,773		10
10a	Therapy		80	321,336	321,416		321,416		321,416		10a
11	Activities	47,206	685	266	48,157		48,157		48,157		11
12	Social Services	32,309			32,309		32,309		32,309		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,912	1,912		15
16	<b>TOTAL Health Care and Programs</b>	1,583,025	98,413	349,390	2,030,828		2,030,828	8,326	2,039,154		16
	<b>C. General Administration</b>										
17	Administrative	53,060			53,060		53,060	24,207	77,267		17
18	Directors Fees										18
19	Professional Services			8,884	8,884		8,884	6,571	15,455		19
20	Dues, Fees, Subscriptions & Promotions			10,215	10,215		10,215	410	10,625		20
21	Clerical & General Office Expenses	24,222	12,462	11,415	48,099		48,099	54,196	102,295		21
22	Employee Benefits & Payroll Taxes			248,878	248,878		248,878		248,878		22
23	Inservice Training & Education							634	634		23
24	Travel and Seminar			745	745		745	1,009	1,754		24
25	Other Admin. Staff Transportation			10,839	10,839		10,839	3,656	14,495		25
26	Insurance-Prop.Liab.Malpractice			24,962	24,962		24,962	1,488	26,450		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							15,760	15,760		27
28	<b>TOTAL General Administration</b>	77,282	12,462	315,938	405,682		405,682	107,931	513,613		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,081,745	407,934	807,060	3,296,739		3,296,739	84,583	3,381,322		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 &amp; ID Number

Sunset Rehabilitation &amp; Hlth C

#0046094

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			122,291	122,291		122,291	58,671	180,962			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			339,947	339,947		339,947	6,709	346,656			32
33	Real Estate Taxes			29,725	29,725		29,725	1,272	30,997			33
34	Rent-Facility & Grounds							78	78			34
35	Rent-Equipment & Vehicles			18,461	18,461		18,461	1,024	19,485			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			510,424	510,424		510,424	67,754	578,178			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,759		126,759		126,759		126,759			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):* Non-allowable Cost	12,928	1,048	167,946	181,922		181,922	(181,922)				43
44	<b>TOTAL Special Cost Centers</b>	12,928	127,807	230,909	371,644		371,644	(181,922)	189,722			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,094,673	535,741	1,548,393	4,178,807		4,178,807	(29,585)	4,149,222			45

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

\*\*See schedule of adjustments attached at end of cost report.

**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	(5,802)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	54,811	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(556)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(143,601)	43		24
25	Fund Raising, Advertising and Promotional	(30,872)	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 <u>See Pg. 5A</u>	(46,809)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (172,879)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	143,294	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 143,294		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (29,585)		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					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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Sunset Rehabilitation & Hlth C

ID# 0046094

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ 419	43	1
2	X-Rays-Part A	(1,280)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,184)	10	3
4	Offset Miscellaneous Food Revenue	(41,400)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(924)	21	5
6	Nonallowable Dues	(1,014)	20	6
7	Offset Repairs and Maintenance Revenue	(246)	6	7
8	Offset Cable TV income	(180)	43	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>	(46,809)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunset Rehabilitation & Hlth C# 0046094

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,252	0	0	0	0	0	0	0	0	0	3,252	1
2	Food Purchase	(41,400)	112	0	0	0	0	0	0	0	0	0	(41,288)	2
3	Housekeeping	0	37	0	0	0	0	0	0	0	0	0	37	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	555	0	0	0	0	0	0	0	0	0	555	5
6	Maintenance	(246)	4,530	0	0	0	0	0	0	0	0	0	4,284	6
7	Other (specify):*	0	1,484	0	0	0	0	0	0	0	0	0	1,484	7
8	<b>TOTAL General Services</b>	<b>(41,646)</b>	<b>9,972</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>(31,674)</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	(2,184)	8,598	0	0	0	0	0	0	0	0	0	6,414	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	1,912	0	0	0	0	0	0	0	0	0	1,912	15
16	<b>TOTAL Health Care and Programs</b>	<b>(2,184)</b>	<b>10,510</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>8,326</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	24,207	0	0	0	0	0	0	0	0	0	24,207	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,571	0	0	0	0	0	0	0	0	0	6,571	19
20	Fees, Subscriptions & Promotions	(1,014)	0	1,424	0	0	0	0	0	0	0	0	410	20
21	Clerical & General Office Expenses	(924)	0	55,120	0	0	0	0	0	0	0	0	54,196	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	634	0	0	0	0	0	0	0	0	634	23
24	Travel and Seminar	0	0	1,009	0	0	0	0	0	0	0	0	1,009	24
25	Other Admin. Staff Transportation	0	0	3,656	0	0	0	0	0	0	0	0	3,656	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,488	0	0	0	0	0	0	0	0	1,488	26
27	Other (specify):*	0	0	15,760	0	0	0	0	0	0	0	0	15,760	27
28	<b>TOTAL General Administration</b>	<b>(1,938)</b>	<b>30,778</b>	<b>79,091</b>	<b>0</b>	<b>107,931</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(45,768)</b>	<b>51,260</b>	<b>79,091</b>	<b>0</b>	<b>84,583</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunset Rehabilitation & Hlth C# 0046094

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	54,811	0	3,860	0	0	0	0	0	0	0	0	58,671	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	6,709	0	0	0	0	0	0	0	0	6,709	32
33	Real Estate Taxes	0	0	1,272	0	0	0	0	0	0	0	0	1,272	33
34	Rent-Facility & Grounds	0	0	78	0	0	0	0	0	0	0	0	78	34
35	Rent-Equipment & Vehicles	0	0	1,024	0	0	0	0	0	0	0	0	1,024	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>54,811</b>	<b>0</b>	<b>12,943</b>	<b>0</b>	<b>67,754</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):*	(181,922)	0	0	0	0	0	0	0	0	0	0	(181,922)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(181,922)</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>(181,922)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(172,879)</b>	<b>51,260</b>	<b>92,034</b>	<b>0</b>	<b>(29,585)</b>	<b>45</b>							

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
Mark Petersen		See Attached Schedule 6E		See Attached Sch 6E		

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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,252	\$ 3,252	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	112	112	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	37	37	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	555	555	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,530	4,530	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,484	1,484	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	8,598	8,598	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,912	1,912	10	
11	V	17 Administrative	0	Petersen Health Care, Inc.	100.00%	24,207	24,207	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,571	6,571	12	
13	V							13	
14	Total		\$			\$ 51,260	\$ *	51,260	14

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

VII. RELATED PARTIES (continued)

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)		
15	V	20 Dues, Fees, Subs and Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,424	\$	1,424	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	55,120		55,120	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	634		634	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,009		1,009	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,656		3,656	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,488		1,488	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	15,760		15,760	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,860		3,860	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,709		6,709	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,272		1,272	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	78		78	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,024		1,024	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 92,034	\$ *	92,034	39

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

**VII. RELATED PARTIES (continued)**

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)	
15	V	1 <u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$	\$	15
16	V	2 <u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%			16
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%			17
18	V	4 <u>Laundry</u>		<u>Petersen Health Care, Inc.</u>	100.00%			18
19	V	5 <u>Utilities</u>		<u>Petersen Health Care, Inc.</u>	100.00%			19
20	V	6 <u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%			20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%			21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%			22
23	V	10A <u>Therapy</u>		<u>Petersen Health Care, Inc.</u>	100.00%			23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%			24
25	V	17 <u>Administrative</u>		<u>Petersen Health Care, Inc.</u>	100.00%			25
26	V	19 <u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%			26
27	V	20 <u>Dues, Fees, Subs and Prmotions</u>		<u>Petersen Health Care, Inc.</u>	100.00%			27
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%			28
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%			29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%			30
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%			31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%			32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%			33
34	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%			34
35	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%			35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%			36
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%			37
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%			38
39	<b>Total</b>		\$			\$	0	\$ *

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

**VII. RELATED PARTIES (continued)**

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			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$			\$	0	\$ *	39

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

Facility Name &amp; ID Number

Sunset Rehabilitation &amp; Hlth C

# 0046094

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.6	2.90	Salary	\$ 24,207	L17, C7	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	\$ 24,207		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 Rehabilitation & Hlth C

# 0046094

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 Petersen Health Care, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 691-8113  
 Fax Number (309) 691-8622

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	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	38,860	\$ 3,252	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	38,860	112	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	38,860	37	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	38,860	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	38,860	555	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	38,860	4,530	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	38,860	1,484	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	38,860	8,598	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	38,860	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	38,860	1,912	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	38,860	24,207	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	38,860	6,571	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	38,860	1,424	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	38,860	55,120	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	38,860	634	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	38,860	1,009	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	38,860	3,656	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	38,860	1,488	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	38,860	15,760	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	38,860	3,860	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	38,860	6,709	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	38,860	1,272	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648		38,860	78	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690		38,860	1,024	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 143,294	25

Facility Name & ID Number

Sunset Rehabilitation & Hlth C

# 0046094

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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		3	4	5	6		7	8	9	10						
		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	LaSalle Bank		X	Mortgage	Varies	08/31/02	\$ 4,050,000	\$ 4,003,965	12/31/13	Varies	\$ 339,947	1						
2												2						
3												3						
4							Home Office Allocation				6,709	4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 4,050,000	\$ 4,003,965			\$ 346,656	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,050,000	\$ 4,003,965			\$ 346,656	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax".  
The real estate tax statement and bill must accompany

1. Real Estate Tax accrual used on 2006 report.		\$	<b>37,227</b>	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.)	2006	\$	<b>34,224</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(3,003)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>34,000</b>	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>Home Office Allocation</b> <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.		\$	<b>30,997</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>31,194</b>	8
	2003	<b>32,956</b>	9
	2004	<b>34,591</b>	10
	2005	<b>33,983</b>	11
	2006		12

Accrual based on prior year tax bill.

<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 Rehabilitation & Hlth C COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0046094

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

**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>06-100-14-00</u>	<u>Long-Term Care Facility</u>	\$ <u>32,952.00</u>	\$ <u>32,952.00</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,272.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>32,952.00</u>	\$ <u>34,224.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 27,554 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2002</u>	<u>\$ 95,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 95,000</b>	<b>3</b>

Facility Name & ID Number Sunset Rehabilitation & Hlth C# 0046094

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	105	2002	1972	\$ 2,315,000	\$ 59,359	30	\$ 77,167	\$ 17,808	\$ 424,418	4
5			2001	413,768	19,482	20	20,688	1,206	134,472	5
6	2		2003	148,271	14,327	20	7,414	(6,913)	33,363	6
7	8		2005	355,587	326	39	9,118	8,792	22,795	7
8	Home Office Allocation									8
	Improvement Type**									
9	Petersen Properties Building Partnership		1990	6,417		15			6,417	9
10	Petersen Properties Building Partnership		1991	10,127		15			10,127	10
11	Petersen Properties Building Partnership		1993	4,719		15	315	315	4,436	11
12	Petersen Properties Building Partnership		1994	1,780		15	119	119	1,626	12
13	Petersen Properties Building Partnership		1995	13,199		20	660	660	8,406	13
14										14
15	Field Audit		1990	1,102		15			1,102	15
16	Drapes		1995	8,206		20	410	410	5,057	16
17	Remodeling		1996	14,630		20	732	732	8,176	17
18	Awning		1996	1,105		20	55	55	610	18
19	Landscaping		1996	4,036		20	202	202	2,357	19
20	Back Taxes on Land		1996	531		20	27	27	263	20
21	Tiling		1997	500		20	25	25	250	21
22	Doors		1997	5,250		20	263	263	2,893	22
23	Tiling		1997	8,228		20	411	411	4,487	23
24	Gutters		1997	2,759		20	138	138	1,484	24
25	Landscaping		1997	1,886		20	94	94	1,011	25
26	Door Closer		1997	1,688		20	84	84	868	26
27	Concrete Slab		1997	1,440		20	72	72	768	27
28	Painting		1997	1,207		20	60	60	645	28
29	Furnace		1997	2,389		20	119	119	1,210	29
30	Awning		1997	4,077		20	204	204	2,142	30
31	Telephone System		1997	1,189		20	59	59	605	31
32	Roof/Windows		1998	36,145		20	1,807	1,807	17,167	32
33	Drapery		1998	1,402		20	70	70	665	33
34	Expansion Design		1998	3,639		20	182	182	1,729	34
35	Flooring/Cove Base		1998	619		20	31	31	295	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Sunset Rehabilitation & Hlth C# 0046094

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	Awnings	1999	\$ 353	\$	20	\$ 18	\$ 18	\$ 153	37
38	Roof (Balance)	1999	1,000		20	50	50	425	38
39	Drapes	2000	1,966		20	98	98	735	39
40	Remove Trees	2000	1,072		20	54	54	405	40
41	Expansion	2000	1,945		20	97	97	732	41
42	Wood	2000	1,072		20	54	54	405	42
43	Land Work	2000	2,510		20	126	126	945	43
44	Flooring	2000	1,168		20	58	58	435	44
45	Shades	2001	1,788		20	89	89	579	45
46	Painting	2001	2,228		20	111	111	722	46
47	Carpet	2001	4,841		20	242	242	1,573	47
48	Carpet	2001	8,000		20	400	400	2,600	48
49	Painting	2001	345		20	17	17	111	49
50	Fire System	2001	42,286		20	2,114	2,114	13,741	50
51	Carpet	2001	2,155		20	108	108	702	51
52	Kitchen Remodeling	2001	43,315		20	2,166	2,166	14,079	52
53	Expansion	2002	7,352		20	368	368	2,026	53
54	Wall	2002	6,000		20	300	300	1,650	54
55	New Addition	2004	3,021		20	151	151	530	55
56	Stairway, sunroom, new addition	2004	218,275		20	10,914	10,914	38,199	56
57	Engineering Fees	2005	2,047		20	102	102	255	57
58	IDPH Planning Fee	2005	2,976		20	149	149	372	58
59	Architect Fees	2005	1,904		20	98	98	241	59
60	Asphalt West Lot	2006	21,480		20	1,074	1,074	1,790	60
61	Air Conditioner	2007	3,000		10	150	150	150	61
62	Wheelchair Ramp	2007	930		15	31	31	31	62
63	Fire Alarm								63
64									64
65									65
66									66
67	2007-Home Office Allocation-Land Improvements		1,450			86	86		67
68	2007-Home Office Allocation-Building Improvements		21,665			529	529		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,777,040	\$ 93,494		\$ 140,280	\$ 46,786	\$ 783,430	70

\*\*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	\$ 368,760	\$ 24,954	\$ 37,038	\$ 12,084	5-10	\$ 326,440	71
72	Current Year Purchases	7,979	393	399	6	10	399	72
73	Fully Depreciated Assets	165,723					165,723	73
74	Home Office Allocation			3,245	3,245			74
75	TOTALS	\$ 542,462	\$ 25,347	\$ 40,682	\$ 15,335		\$ 492,562	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	Facility	1990 Dodge Intrepid	1994	\$ 32,448	\$ 1,675	\$	\$ (1,675)	4	\$ 32,448	76
77	Facility	1997 Ford E350 Van	1997	41,836				4	41,836	77
78	Facility	2001 Dodge Caravan	2001	47,863				4	47,863	78
79	Facility	2001 Chevy	2002	17,143	1,775		(1,775)	4	17,143	79
80	TOTALS			\$ 139,290	\$ 3,450	\$	\$ (3,450)		\$ 139,290	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)	\$ 4,553,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 122,291	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,962	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 58,671	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,415,282	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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:				\$			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>78</u>			6
7	TOTAL				\$ <u>78</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 19,485 Description: See Schedule 14A

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

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>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

\* 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.

Sunset Rehabilitation & Hlth C

0046094

Period Beginning 01/01/2007

Period End 12/31/2007

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Copier	\$ 4,617
Dishwasher	199
Medical Equipment	13,645
Home Office Allocation	<u>1,024</u>
	<u><u>19,485</u></u>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	L. 10A, C. 3	hrs	\$	567	\$ 136,081	\$	567	\$ 136,081	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		81	19,352		81	19,352	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 2,3	hrs		691	165,903	80	691	165,983	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescrpts				126,759		126,759	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>			\$	1,339	\$ 321,336	\$ 126,839	1,339	\$ 448,175	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 Rehabilitation & Hlth C**

# **0046094**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2007**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,106,960	\$ 2,106,960	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	808,295	808,295	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,875	18,875	6
7	Other Prepaid Expenses	14,724	14,724	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	16,381	16,381	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,965,235	\$ 2,965,235	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		95,000	13
14	Buildings, at Historical Cost	2,873,789	3,254,291	14
15	Leasehold Improvements, at Historical Cost	960,878	522,749	15
16	Equipment, at Historical Cost	699,896	681,752	16
17	Accumulated Depreciation (book methods)	(1,160,507)	(1,415,282)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	1,790,000	1,790,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,164,056	\$ 4,928,510	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,129,291	\$ 7,893,745	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 565,654	\$ 565,654	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,982	128,982	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,335	4,335	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,000	34,000	32
33	Accrued Interest Payable	28,467	28,467	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	38,122	38,122	36
37	<u>Due to Related Parties</u>	13,126	13,126	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 812,686	\$ 812,686	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,003,965	4,003,965	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,003,965	\$ 4,003,965	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,816,651	\$ 4,816,651	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,312,640	\$ 3,077,094	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 8,129,291	\$ 7,893,745	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,680,282</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</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>2,680,285</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>632,355</b>	<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>632,355</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>3,312,640</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,878,610	1
2	Discounts and Allowances for all Levels	185,304	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,063,914	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	461,160	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 461,160	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	1,186	14
15	Telephone, Television and Radio	180	15
16	Rental of Facility Space		16
17	Sale of Drugs	227,262	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,253	20
21	Other Medical Services	4,639	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 242,520	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Miscellaneous -see attached Schedule 19A</u>	43,568	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 43,568	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,811,162	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	860,229	31
32	Health Care	2,030,828	32
33	General Administration	405,682	33
	<b>B. Capital Expense</b>		
34	Ownership	510,424	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	308,681	35
36	Provider Participation Fee	62,963	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,178,807	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	632,355	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 632,355	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

\*\*\* 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.

Sunset Rehabilitation & Hlth C

0046094

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Medical Supplies	2,184
Repairs & Maint.	246
Food	40,214
Office Supplies	<u>924</u>

43,568

Facility Name & ID Number **Sunset Rehabilitation & Hlth C**

# **0046094**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

**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	2,080	2,080	\$ 60,000	\$ 28.85	1
2	Assistant Director of Nursing	2,080	2,080	39,163	18.83	2
3	Registered Nurses	4,644	4,907	113,020	23.03	3
4	Licensed Practical Nurses	24,421	25,478	486,331	19.09	4
5	CNAs & Orderlies	75,023	77,358	723,469	9.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,029	2,108	18,856	8.94	9
10	Activity Assistants	1,572	1,572	11,104	7.06	10
11	Social Service Workers	2,892	3,012	32,309	10.73	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	21,538	10.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,561	16,545	133,436	8.07	15
16	Dishwashers					16
17	Maintenance Workers	3,720	3,720	37,219	10.01	17
18	Housekeepers	20,754	21,611	186,548	8.63	18
19	Laundry	5,407	5,766	42,697	7.40	19
20	Administrator	2,080	2,080	53,060	25.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,420	2,444	24,222	9.91	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	6,822	6,861	111,701	16.28	33
34	TOTAL (lines 1 - 33)	173,585	179,702	\$ 2,094,673 *	\$ 11.66	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	49	\$ 2,573	L. 1, C. 3	35
36	Medical Director	Monthly	23,587	L. 9, C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L. 10, C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	\$ 27,360		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Sunset Rehabilitation & Hlth C  
0046094  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 20A**

**XVIII. Staffing and Salary Costs**  
**Line 32-Other**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reportin g Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
Care Plan Coordinator	3,886	3,885	81,527	20.99
Marketing	931	931	12,928	13.89
Transportation	2,005	2,045	17,246	8.43
<b>Total Line 32-Other</b>	<b>6,822</b>	<b>6,861</b>	<b>111,701</b>	<b>16.28</b>

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Margaret Ferris	Administrator	0	\$ 53,060	Workers' Compensation Insurance	\$ 30,379	IDPH License Fee	\$		
				Unemployment Compensation Insurance	37,515	Advertising: Employee Recruitment	103		
				FICA Taxes	158,362	Health Care Worker Background Check	2,450		
				Employee Health Insurance	19,100	(Indicate # of checks performed <u>245</u> )			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Misc Dues & Subscriptions	1,284		
						Home Office Allocation	1,424		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Retirement	3,017	LTC Solutions license	1,600		
(List each licensed administrator separately.)			\$ 53,060	Employee Relations	505	IHCA	4,778		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount				Less: Public Relations Expense		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 0				( )		
							Non-allowable advertising ( )		
							Yellow page advertising ( )		
TOTAL (agree to Schedule V, line 17, col. 3)			\$				TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)							\$ 10,625		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
McGladrey & Pullen LLC	Accounting		\$ 6,080				Out-of-State Travel	\$	
E Health Data Solutions	Computer Services		2,194						
AT & T	Computer Services		160	N/A			In-State Travel		
Miscellaneous	Computer Services		450						
							Seminar Expense	745	
							Home Office Allocation	1,009	
							Entertainment Expense ( )		
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				TOTAL	\$ 1,754
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,884						

\* Attach copy of IMRF notifications

\*\*See instructions.

Sunset Rehabilitation & Hlth C  
0046094  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 21A**

**XIX. SUPPORT SCHEDULE  
C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		
Non-allowable legal expense		8,884

**Home Office Allocation**

Pearl & Associates	Legal	43
Addy Bush & Assoc	Legal	22
Registered Agent Solutions	Legal	4
Heyl, Royster, Voelker & Allen	Legal	95
Duane Morris	Legal	148
Ginoli & Co.	Accountants	1,502
RSM McGladrey	Accountants	260
McGladrey & Pullen	Accountants	397
Emdeon Business Services	Computer Services	103
Advanced Answers on Demand	Computer Services	2,786
Access 2 Go	Computer Services	210
Ivans	Computer Services	184
Kemper Technology	Computer Services	437
Adminastar Federal	Computer Services	54
Logmein	Computer Services	34
E-Health Data Solutions	Computer Services	273
Miscellaneous Vendors	Miscellaneous	19

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u><u>15,455</u></u>
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Facility Name & ID Number Sunset Rehabilitation & Hlth C# 0046094Report Period Beginning: 01/01/2007Ending: 12/31/2007**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. IHCA \$4778
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,527 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 during this cost report period. \$ 62,963  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 41,400
- (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? Adequate records have been maintained.
- 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: Ginoli & Co. 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. Audit currently 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees