



Facility Name & ID Number SUNSET HOME

# 0011643 Report Period Beginning: 10/1/07 Ending: 9/30/08

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	6,954	1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,632	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,346	5
6		ICF/DD 16 or Less			6
7	202	TOTALS	202	73,932	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF		3	4,829	4,832	8
9	SNF/PED					9
10	ICF	24,825	19,643		44,468	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,825	19,646	4,829	49,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.68%

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 4,829

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: 10/1/07 Ending: 9/30/08

**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	521,412	29,146	11,311	561,869		561,869		561,869		1
2	Food Purchase		256,810		256,810		256,810		256,810		2
3	Housekeeping	202,191	27,584	178	229,953		229,953		229,953		3
4	Laundry	42,664	1,368	140,511	184,543		184,543		184,543		4
5	Heat and Other Utilities			453,858	453,858		453,858		453,858		5
6	Maintenance	125,833	32,140	42,456	200,429		200,429	(13,266)	187,163		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	892,100	347,048	648,314	1,887,462		1,887,462	(13,266)	1,874,196		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	3,312,996	75,489	125,463	3,513,948		3,513,948		3,513,948		10
10a	Therapy		880	359,160	360,040		360,040		360,040		10a
11	Activities	123,760	6,401	2,984	133,145		133,145		133,145		11
12	Social Services	102,656	84	18,463	121,203		121,203		121,203		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,539,412	82,854	506,070	4,128,336		4,128,336		4,128,336		16
	<b>C. General Administration</b>										
17	Administrative	90,675			90,675		90,675		90,675		17
18	Directors Fees										18
19	Professional Services			59,116	59,116		59,116	(6,964)	52,152		19
20	Dues, Fees, Subscriptions & Promotions			21,521	21,521		21,521	(230)	21,291		20
21	Clerical & General Office Expenses	226,255	7,403	157,342	391,000		391,000	(75)	390,925		21
22	Employee Benefits & Payroll Taxes			1,166,279	1,166,279	(9,176)	1,157,103		1,157,103		22
23	Inservice Training & Education			293	293		293		293		23
24	Travel and Seminar			2,701	2,701		2,701	(200)	2,501		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			162,040	162,040		162,040		162,040		26
27	Other (specify):* <b>BAD DEBT</b>			31,807	31,807		31,807	(31,807)			27
28	<b>TOTAL General Administration</b>	316,930	7,403	1,601,099	1,925,432	(9,176)	1,916,256	(39,276)	1,876,980		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,748,442	437,305	2,755,483	7,941,230	(9,176)	7,932,054	(52,542)	7,879,512		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:

10/1/07

Ending:

9/30/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			584,745	584,745	(132,679)	452,066		452,066			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			255,338	255,338	(123,676)	131,662	(764)	130,898			32
33	Real Estate Taxes			796	796		796		796			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			840,879	840,879	(256,355)	584,524	(764)	583,760			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		95,897		95,897		95,897		95,897			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,879	93,879		93,879		93,879			42
43	Other (specify):* <b>SEE LIST ATTACHED</b>			465,143	465,143	265,531	730,674	(730,674)				43
44	<b>TOTAL Special Cost Centers</b>		95,897	559,022	654,919	265,531	920,450	(730,674)	189,776			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,748,442	533,202	4,155,384	9,437,028		9,437,028	(783,980)	8,653,048			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:

**10/1/07**

Ending:

**9/30/08**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(11,391)	6		5
6	Rented Facility Space	(1,875)	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				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	(75)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,964)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,807)	27		24
25	Fund Raising, Advertising and Promotional	(90,440)	43		25
	Income Taxes and Illinois Personal				
26	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>	\$ (142,552)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

**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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	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>	\$ (142,552)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SUNSET HOME

ID# 0011643

Report Period Beginning: 10/1/07

Ending: 9/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	CHAMBER OF COMMERCE DUES	\$ (230)	20	1
2	INTEREST ON GIFT ANNUITIES	(764)	32	2
3	VILLA INDEPENDENT LIVING UNITS	(540,186)	43	3
4	SENIOR APARTMENTS	(100,048)	43	4
5	OUT OF STATE TRAVEL	(200)	24	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>	(641,428)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME# 0011643

Report Period Beginning:

10/1/07

Ending:

9/30/08

## 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	(13,266)	0	0	0	0	0	0	0	0	0	0	(13,266)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(13,266)</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>(13,266)</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	(6,964)	0	0	0	0	0	0	0	0	0	0	(6,964)	19
20	Fees, Subscriptions & Promotions	(230)	0	0	0	0	0	0	0	0	0	0	(230)	20
21	Clerical & General Office Expenses	(75)	0	0	0	0	0	0	0	0	0	0	(75)	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	(200)	0	0	0	0	0	0	0	0	0	0	(200)	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):*	(31,807)	0	0	0	0	0	0	0	0	0	0	(31,807)	27
28	<b>TOTAL General Administration</b>	<b>(39,276)</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>(39,276)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(52,542)</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>(52,542)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number SUNSET HOME# 0011643

Report Period Beginning:

10/1/07

Ending:

Summary B

9/30/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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>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>(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):*	(730,674)	0	0	0	0	0	0	0	0	0	0	(730,674)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(730,674)</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>(730,674)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(783,980)</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>(783,980)</b>	<b>45</b>

Facility Name & ID Number

SUNSET HOME

# 0011643

Report Period Beginning:

10/1/07

Ending:

9/30/08

**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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number **SUNSET HOME** # **0011643** Report Period Beginning: **10/1/07** Ending: **9/30/08**

**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								<b>TOTAL</b>	\$		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: **10/1/07** Ending: **9/30/08**

**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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

SUNSET HOME

# 0011643

Report Period Beginning:

10/1/07

Ending:

9/30/08

**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										
										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	\$12,700.00	12/19/03	\$ 2,150,000	\$ 1,965,187	12/19/28	0.0450	\$ 79,784	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	MERCANTILE		X	LINE OF CREDIT		12/21/07	1,000,000	682,529	12/21/08	0.0550	51,114	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>				\$12,700.00		\$ 3,150,000	\$ 2,647,716			\$ 130,898	9							
<b>B. Non-Facility Related*</b>																			
10	MERCANTILE		X	APARTMENTS PERM LOAN	\$15,922.00	12/19/03	2,850,000	2,643,316	12/19/28	0.0450	123,676	10							
11	GIFT ANNUITIES		X	NONE							764	11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>				\$15,922.00		\$ 2,850,000	\$ 2,643,316			\$ 124,440	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 6,000,000	\$ 5,291,032			\$ 255,338	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:

10/1/07 Ending:

9/30/08

**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:**

	1	2	3	4	
A. Land.	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 &amp; ID Number SUNSET HOME

# 0011643

Report Period Beginning:

10/1/07

Ending:

9/30/08

**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	34	1958	1958	\$ 354,000	\$ 3,540	50	\$ 3,540	\$	\$ 354,000	4
5	71	1971	1971	1,218,562	24,371	50	24,371		901,708	5
6	49	1972	1972	472,577	9,452	50	9,452		347,350	6
7	5	1987	1987	68,497		20			68,497	7
8	43	2001	2001	2,500,281	83,343	30	83,343		583,399	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		36,817	10
11	BUILDINGS & IMPROVEMENTS		1977	14,179		20			14,179	11
12	BUILDINGS & IMPROVEMENTS		1978	442,103	8,842	50	8,842		269,797	12
13	BUILDINGS & IMPROVEMENTS		1979	13,639	273	50	273		8,050	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		158,551	18
19	BUILDINGS & IMPROVEMENTS		1987	321,886		10-20			321,885	19
20	BUILDINGS & IMPROVEMENTS		1988	36,315	97	10-20	97		36,315	20
21	BUILDINGS & IMPROVEMENTS		1989	99,114	2,399	10-20	2,399		97,460	21
22	BUILDINGS & IMPROVEMENTS		1990	36,949	1,847	20	1,847		33,481	22
23	BUILDINGS & IMPROVEMENTS		1992	11,222	156	10-20	156		10,644	23
24	BUILDINGS & IMPROVEMENTS		1993	31,474	1,151	5-20	1,151		25,854	24
25	BUILDINGS & IMPROVEMENTS		1994	9,466	382	5-20	382		7,366	25
26	BUILDINGS & IMPROVEMENTS		1995	99,649	5,321	5-15	5,321		92,181	26
27	BUILDINGS & IMPROVEMENTS		1996	25,111	1,256	20	1,256		15,250	27
28	BUILDINGS & IMPROVEMENTS		1997	356,451	16,858	5-20	16,858		214,296	28
29	BUILDINGS & IMPROVEMENTS		1998	107,004	5,192	5-20	5,192		58,682	29
30	BUILDINGS & IMPROVEMENTS		1999	1,696	170	10	170		1,612	30
31	BUILDINGS & IMPROVEMENTS		2000	30,811	1,540	20	1,540		11,964	31
32	BUILDINGS & IMPROVEMENTS		2001	24,121	2,230	10-20	2,230		15,515	32
33	BUILDINGS & IMPROVEMENTS		2002	48,990	4,460	10-20	4,460		28,554	33
34	BUILDINGS & IMPROVEMENTS		2004	16,042	1,311	5-20	1,311		5,251	34
35										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 &amp; ID Number SUNSET HOME

# 0011643

Report Period Beginning:

10/1/07

Ending:

9/30/08

## 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	RENOVATION 3RD FLOOR SHOWER ROOM	2006	\$ 56,337	\$ 2,817	20	\$ 2,817	\$	\$ 7,042	37
38	RAMPS AND RAILS	2007	2,939	196	15	196		294	38
39	WALLGUARD	2007	5,808	387	15	387		581	39
40	CONCRETE WORK	2007	13,500	900	15	900		1,350	40
41	THE FOLLOWING RENOVATION 1ST, 2ND 4TH FLOOR WEST:								41
42	LEANDER CONSTRUCTION	2007	2,188,906	87,556	25	87,556		131,334	42
43	LZT ARCHITECT	2007	233,722	9,349	25	9,349		14,023	43
44	ATTORNEY FEES INTEREST CAPITALIZED	2007	52,310	2,092	25	2,092		3,139	44
45	IDPH APPROVED PLANS	2007	9,600	384	25	384		576	45
46	3 CASCADE BATHING SYSTEM	2007	26,674	1,067	25	1,067		1,600	46
47	CASCADE SPA	2007	8,558	342	25	342		513	47
48	ALARMS COMMUNICATIONS	2007	17,577	703	25	703		1,055	48
49	ASBESTOS REMOVAL	2007	43,644	1,746	25	1,746		2,619	49
50	ADDITIONAL ARCHITECT ENGINEERING FEES	2007	51,320	2,053	25	2,053		3,079	50
51	DRYWALL	2007	105,176	4,207	25	4,207		6,311	51
52	LEANDER CONSTRUCTION	2008	52,103	1,042	25	1,042		1,042	52
53	LZT ARCHITECT	2008	4,117	82	25	82		82	53
54	ATTORNEY FEES	2008	1,588	32	25	32		32	54
55	TOTAL RENOVATION 1ST,2ND,4TH \$2,795,295								55
56	DRAPES AND HARDWARE 1,2,4	2007	42,347	4,235	10	4,235		6,352	56
57									57
58	FIXED EQUIPMENT	1971	814,827		25			814,827	58
59	FIXED EQUIPMENT	1972	253,064		25			253,063	59
60	FIXED EQUIPMENT	1978	280,726		25			280,726	60
61	FIXED EQUIPMENT	1979	13,938		10			13,938	61
62	FIXED EQUIPMENT	1984	23,531		10			23,531	62
63	FIXED EQUIPMENT	1985	117,689		5-20			117,687	63
64	FIXED EQUIPMENT	1986	13,909		10-15			13,908	64
65	FIXED EQUIPMENT	1987	12,320		10-20			12,320	65
66	FIXED EQUIPMENT	1988	8,162	78	10-20	78		8,162	66
67	FIXED EQUIPMENT	1989	4,670		15			4,670	67
68	FIXED EQUIPMENT	1993	259,307	11,891	10-20	11,891		203,817	68
69	FIXED EQUIPMENT	1995	188,017	9,549	10-20	9,549		127,183	69
70	TOTAL (lines 4 thru 69)		\$ 11,615,026	\$ 322,722		\$ 322,722	\$	\$ 5,818,878	70

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

Facility Name &amp; ID Number SUNSET HOME

# 0011643

Report Period Beginning:

10/1/07

Ending:

9/30/08

## 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>		\$ 11,615,026	\$ 322,722		\$ 322,722	\$	\$ 5,818,878	1
2	FIXED EQUIPMENT	1996	10,809	88	10-15	88		10,590	2
3	FIXED EQUIPMENT	1997	35,461	1,812	15-20	1,812		20,527	3
4	FIXED EQUIPMENT	1998	173,001	8,865	10-20	8,865		93,001	4
5	FIXED EQUIPMENT	1999	8,744	526	15-20	526		4,643	5
6	FIXED EQUIPMENT	2000	272,461	14,155	15-20	14,155		116,182	6
7	FIXED EQUIPMENT	2001	40,619	2,424	10-25	2,424		16,698	7
8	FIXED EQUIPMENT	2002	81,604	5,504	10-25	5,504		33,410	8
9	FIXED EQUIPMENT	2003	105,075	6,172	15-20	6,172		31,866	9
10	FIXED EQUIPMENT	2004	142,116	8,970	15-25	8,970		35,478	10
11	NEW 4" RPZ VALVE SPRINKLER SYSTEM	2005	3,556	142	25	142		498	11
12	REPAIR BOILER "2	2005	9,217	614	15	614		2,151	12
13	NEW DAMPER WEST PENTHOUSE	2005	4,556	304	15	304		1,063	13
14	NEW 480 WATT DISCONNECT	2005	6,268	313	20	313		940	14
15	BUSBOY DISPOSER	2005	1,708	114	15	114		399	15
16	WANDERGUARD	2005	4,048	270	15	270		945	16
17	NEW CARD PHONE SYSTEM	2005	1,192	119	10	119		417	17
18	BOILER "3 SECTION REPLACEMENT	2005	5,289	353	15	353		2,468	18
19	NEW BOILER W/GASKETS	2005	2,588	173	15	173		1,208	19
20	RELOCATE DOOR ALARM SYSTEM	2005	12,898	860	15	860		6,019	20
21	SUPPRESSION SYSTEM MAIN KITCHEN	2007	4,827	193	25	193		290	21
22	OUTDOOR EMERGENCY LIGHTING	2007	9,680	645	15	645		968	22
23	CHILLER REPLACEMENT	2008	24,923	831	15	831		831	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,575,666	\$ 376,169		\$ 376,169	\$	\$ 6,199,470	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:

10/1/07

Ending:

9/30/08

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		\$ 12,575,666	\$ 376,169		\$ 376,169	\$	\$ 6,199,470	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		12			18,601	6
7	LAND IMPROVEMENTS	1997	4,800	192	25	192		2,208	7
8	LAND IMPROVEMENTS	1999	44,219	3,685	12	3,685		35,008	8
9	LAND IMPROVEMENTS	2000	17,559	707	10-25	707		12,756	9
10	LAND IMPROVEMENTS	2001	1,952	195	10	195		1,463	10
11	LAND IMPROVEMENTS	2003	8,404	560	15	560		3,080	11
12	LAND IMPROVEMENTS	2004	3,450	230	15	230		1,035	12
13	SEEDING & IMPROVEMENT SO 4TH	2006	20,477	2,048	10	2,048		5,120	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	6								27
28									28
29									29
30									30
31	ROUNDING		(6)	(11)		(11)		(2)	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,761,714	\$ 383,775		\$ 383,775	\$	\$ 6,345,331	34

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

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 607,543	\$ 54,402	\$ 54,402			\$ 336,510	71
72	Current Year Purchases	38,739	1,291	1,291		15	1,291	72
73	Fully Depreciated Assets	286,663					286,663	73
74								74
75	<b>TOTALS</b>	\$ 932,945	\$ 55,693	\$ 55,693			\$ 624,464	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	56,836	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216				4	36,216	78
79	RESIDENT TRANSPORT	2005 TRANSPORT BUS	2005	50,391	12,598	12,598		4	44,093	79
80	<b>TOTALS</b>			\$ 166,964	\$ 12,598	\$ 12,598			\$ 160,666	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)	\$ 14,050,330	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 452,066	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 452,066	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)	\$ 7,130,461	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	\$ 1,732,382	\$ 50,004	\$ 855,712	86
87	SUNSET APARTMENTS	2,786,563	82,675	403,180	87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$ 4,518,945	\$ 132,679	\$ 1,258,892	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

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

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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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	<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	10a-3	hrs	\$		\$ 151,309	\$		\$ 151,309	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			13,480	16		13,496	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			194,371	864		195,235	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				95,897		95,897	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 359,160	\$ 96,777		\$ 455,937	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**

# **0011643**

Report Period Beginning: **10/1/07**

Ending: **9/30/08**

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

As of **9/30/08** (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	\$ 86,811	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	855,976		3
4	Supply Inventory (priced at <b>COST</b> )	52,317		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,212		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>	\$ 1,016,316	\$	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	12,761,714		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,099,909		16
17	Accumulated Depreciation (book methods)	(7,130,461)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,140,549		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>LIST ATTACHED</b>	5,311,456		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 14,371,874	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 15,388,190	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 882,707	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	433,633		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,409		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>SUNSET APARTMENTS</b>	113,368		36
37	<b>HEALTH CLAIMS PAYABLE</b>	108,660		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,541,777	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	2,647,716		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<b>N/P SUNSET APARTMENTS</b>	2,643,316		43
44	<b>REF FEES DEFERRED REVENUE</b>	41,710		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,332,742	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,874,519	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 8,513,671	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 15,388,190	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>9,190,186</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>9,190,186</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(676,515)	<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>	\$ (676,515)	<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>8,513,671</b>	<b>24</b> *

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

Facility Name &amp; ID Number SUNSET HOME

# 0011643

Report Period Beginning: 10/1/07

Ending:

9/30/08

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	\$ 8,911,456	1
2	Discounts and Allowances for all Levels	(1,286,258)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,625,198	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	1,875	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>	\$ 1,875	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	236,748	24
25	Interest and Other Investment Income***	(19,911)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 216,837	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>	(144)	28
28a	<b>SEE ATTACHED</b>	857,631	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 857,487	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,701,397	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,887,462	31
32	Health Care	4,128,336	32
33	General Administration	1,857,140	33
<b>B. Capital Expense</b>			
34	Ownership	584,524	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	95,897	35
36	Provider Participation Fee	93,879	36
<b>D. Other Expenses (specify):</b>			
37	<b>FUND DEVELOPMENT</b>	90,440	37
38	<b>SUNSET APARTMENTS</b>	540,186	38
39	<b>VILLA INDEPENDENT UNITS</b>	100,048	39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,377,912	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(676,515)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (676,515)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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:

**10/1/07**

Ending:

**9/30/08**

**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	1,757	1,951	\$ 54,817	\$ 28.10	1
2	Assistant Director of Nursing	1,887	2,269	64,527	28.44	2
3	Registered Nurses	23,331	25,573	499,054	19.51	3
4	Licensed Practical Nurses	64,729	70,863	1,108,308	15.64	4
5	CNAs & Orderlies	132,566	143,236	1,493,426	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,864	2,310	29,796	12.90	9
10	Activity Assistants	10,448	11,312	93,964	8.31	10
11	Social Service Workers	5,761	6,194	75,545	12.20	11
12	Dietician					12
13	Food Service Supervisor	1,847	2,091	38,273	18.30	13
14	Head Cook	1,915	2,091	32,318	15.46	14
15	Cook Helpers/Assistants	41,116	44,793	408,165	9.11	15
16	Dishwashers	3,790	4,204	42,656	10.15	16
17	Maintenance Workers	6,554	7,546	96,055	12.73	17
18	Housekeepers	20,779	22,414	190,845	8.51	18
19	Laundry	3,753	4,166	42,664	10.24	19
20	Administrator	2,059	2,333	90,675	38.87	20
21	Assistant Administrator					21
22	Other Administrative	5,784	6,210	112,085	18.05	22
23	Office Manager					23
24	Clerical	7,794	8,948	114,169	12.76	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	1,863	2,048	30,941	15.11	31
32	Other Health Care(specify)	6,274	6,819	73,421	10.77	32
33	Other(specify)	3,667	4,104	56,738	13.83	33
34	TOTAL (lines 1 - 33)	349,538	381,475	\$ 4,748,442 *	\$ 12.45	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	\$ 9,862	1-3	35
36	Medical Director	3,600	10-3	36
37	Medical Records Consultant	3,444	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,213	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	1,695	11-3	44
45	Social Service Consultant	3,012	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,826		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





Facility Name &amp; ID Number SUNSET HOME

# 0011643

Report Period Beginning: 10/1/07

Ending: 9/30/08

**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 \$9,103
- (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. \$ 41,371 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. \$ 93,879  
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: GRAY HUNTER STENN LLP 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. WILL BE SENT WHEN COMPLET
- (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.

SUNSET HOME

#0011643

10/01/07-9/30/08

XVIII STAFFING & SALARY COSTS

	<u>1</u> # OF HRS. ACTUALLY WORKED	<u>2</u> # OF HRS. PAID AND ACCRUED	<u>3</u> TOT SALA AND W
<u>LINE 32 - OTHER</u>			
NRS-SUPPLY COORDINATOR	115	138	
NRS- TRANSPORTER	2,248	2,489	2
SOC SERV- DIRECTOR	1,952	2,091	2
NRS- CLERICAL	1,959	2,101	2
	<u>6,274</u>	<u>6,819</u>	<u>7</u>
 <u>LINE 33 - OTHER</u>			
MAINTENANCE DIRECTOR	1,047	1,306	2
	931	977	1
	1,689	1,821	1
	<u>3,667</u>	<u>4,104</u>	<u>5</u>

SUNSET HOME #0011643  
BALANCE SHEET- SCH XV  
SEPTEMBER 30, 2008

OPERATING

LINE 23-OTHER

VILLA BUILDING & EQUIPMENT NET OF DEPRECIATION (855,712)	876,670
SUNSET APARTMENTS LAND, BUILDING & EQUIPMENT NET OF DEPRECIATION 403,18	2,833,383
UNAMORTIZED BOND COSTS	86,047
ASSETS INTERNALLY (BOARD) DESIGNATED	115,327
ADDITIONAL LAND COSTS	395,311
LAND HELD FOR EXPANSION	1,004,718
	<hr/>
	5,311,456
	<hr/> <hr/>

SUNSET HOME

#0011643

SEPTEMBER 30, 2008

An interest income offset is not applicable at 9/30/08 because of the following reasons.

- 1) There has been a loss from operations for the last twenty-three years. So no additional monies have been generated from operations for investment purposes.
- 2) The majority of investments are derived from contributions and endowments.

SUNSET HOME  
#0011643  
10/01/07-9/30/08

XVII INCOME STATEMENT LINE 28 OTHER REVENUE

VILLA INDEPENDENT LIVING	136,779
SUNSET APARTMENTS RENTAL FEES	702,260
MISCELLANEOUS INCOME	<u>18,592</u>
	<u><u>857,631</u></u>

SUNSET HOME #0011643									
COST CENTER SCH V									
10/01/07-9/30/08									
						RECLASS			ADJUSTED
	SALARY	SUPPLIES	OTHER	TOTAL	RECLASS	TOTAL	ADJUST		TOTAL
	1	2	3	4	5	6	7		8
LINE 43-OTHER									
FUND DEVELOP.			81,264	81,264	9,176	90,440	(90,440)		0
SUNSET APARTMENTS			333,835	333,835	206,351	540,186	(540,186)		0
VILLA			50,004	50,004	50,044	100,048	(100,048)		0
	0	0	465,103	465,103	265,571	730,674	(730,674)		0