



Facility Name & ID Number Sunset Rehabilitation & Hlth C

# 0046094 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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 N/A

	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	<u>25</u>	Skilled (SNF)	<u>25</u>	<u>9,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>90</u>	Intermediate (ICF)	<u>90</u>	<u>32,940</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>42,090</u>	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			<u>2,213</u>	<u>2,213</u>	8
9	SNF/PED					9
10	ICF	<u>25,525</u>	<u>6,988</u>		<u>32,513</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,525</u>	<u>6,988</u>	<u>2,213</u>	<u>34,726</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.50%

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 2,213

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Sunset Rehabilitation & Hlth C # 0046094 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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	146,138	21,783	735	168,656		168,656	6,172	174,828		1
2	Food Purchase		214,305		214,305		214,305	(46,604)	167,701		2
3	Housekeeping	180,645	25,903		206,548		206,548	46	206,594		3
4	Laundry	37,272	13,528		50,800		50,800	3	50,803		4
5	Heat and Other Utilities			129,939	129,939		129,939	640	130,579		5
6	Maintenance	46,810	19,973	42,279	109,062		109,062	3,772	112,834		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,518	1,518		7
8	<b>TOTAL General Services</b>	<b>410,865</b>	<b>295,492</b>	<b>172,953</b>	<b>879,310</b>		<b>879,310</b>	<b>(34,453)</b>	<b>844,857</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,500	22,500		22,500		22,500		9
10	Nursing and Medical Records	1,332,901	83,882	3,014	1,419,797		1,419,797	9,291	1,429,088		10
10a	Therapy		25	372,501	372,526		372,526		372,526		10a
11	Activities	48,400	836	1,958	51,194		51,194		51,194		11
12	Social Services	27,061	16		27,077		27,077		27,077		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,870	1,870		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,408,362</b>	<b>84,759</b>	<b>399,973</b>	<b>1,893,094</b>		<b>1,893,094</b>	<b>11,161</b>	<b>1,904,255</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	55,675			55,675		55,675	48,050	103,725		17
18	Directors Fees										18
19	Professional Services			5,005	5,005		5,005	5,423	10,428		19
20	Dues, Fees, Subscriptions & Promotions			12,642	12,642		12,642	1,349	13,991		20
21	Clerical & General Office Expenses	18,374	10,380	6,620	35,374		35,374	59,662	95,036		21
22	Employee Benefits & Payroll Taxes			258,579	258,579		258,579		258,579		22
23	Inservice Training & Education							366	366		23
24	Travel and Seminar							367	367		24
25	Other Admin. Staff Transportation			6,291	6,291		6,291	4,748	11,039		25
26	Insurance-Prop.Liab.Malpractice			25,377	25,377		25,377	289	25,666		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							17,167	17,167		27
28	<b>TOTAL General Administration</b>	<b>74,049</b>	<b>10,380</b>	<b>314,514</b>	<b>398,943</b>		<b>398,943</b>	<b>137,421</b>	<b>536,364</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,893,276</b>	<b>390,631</b>	<b>887,440</b>	<b>3,171,347</b>		<b>3,171,347</b>	<b>114,129</b>	<b>3,285,476</b>		<b>29</b>

\*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:

1/1/2008

Ending:

12/31/2008

## 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			108,998	108,998		108,998	75,778	184,776			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			254,473	254,473		254,473	4,595	259,068			32
33	Real Estate Taxes			32,153	32,153		32,153	881	33,034			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,166	27,166		27,166	751	27,917			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			422,790	422,790		422,790	82,005	504,795			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,478		74,478		74,478		74,478			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,136	63,136		63,136		63,136			42
43	Other (specify):* Non-allowable Cost	7,915	1,150	122,034	131,099		131,099	(131,099)				43
44	<b>TOTAL Special Cost Centers</b>	7,915	75,628	185,170	268,713		268,713	(131,099)	137,614			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,901,191	466,259	1,495,400	3,862,850		3,862,850	65,035	3,927,885			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(46,705)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,864)	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	69,209	30		9
10	Interest and Other Investment Income	(26)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(215)	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	(4,731)	43		18
19	Entertainment				19
20	Contributions	(1,200)	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	(99,936)	43		24
25	Fund Raising, Advertising and Promotional	(16,076)	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 See Pg. 5A	(5,460)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (111,004)		\$	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)	176,039	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 176,039		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 65,035		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (132)	43	1
2	X-Rays-Part A	(2,691)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,422)	10	3
4	Resident Flowers	(254)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(637)	21	5
6	Nonallowable Dues	(324)	20	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
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36				36
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,460)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	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%	\$ 6,172	\$ 6,172	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	101	101	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	46	46	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	640	640	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,772	3,772	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,518	1,518	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,713	10,713	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,870	1,870	10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	48,050	48,050	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,423	5,423	12
13	V							13
14	Total		\$			\$ 78,308	\$ * 78,308	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 Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,673	\$ 1,673
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	60,299	60,299
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	366	366
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	367	367
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,748	4,748
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	289	289
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	17,167	17,167
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	6,569	6,569
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,621	4,621
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	881	881
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0	
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	751	751
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 97,731	\$ * 97,731

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

Facility Name &amp; ID Number

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# 0046094

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	1,780,624	1.44	2.40	Salary	48,050	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	\$ 48,050		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: 1/1/2008Ending: 2/31/2008

## 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	1,413,604	69	\$ 251,260	\$ 250,687	34,726	\$ 6,172	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	34,726	101	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	34,726	46	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	34,726	3	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	34,726	640	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	34,726	3,772	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	34,726	1,518	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	34,726	10,713	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	34,726	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	34,726	1,870	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	34,726	48,050	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	34,726	5,423	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	34,726	1,673	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	34,726	60,299	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	34,726	366	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	34,726	367	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	34,726	4,748	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	34,726	289	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	34,726	17,167	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	34,726	6,569	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	34,726	4,621	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	34,726	881	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	34,726	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	34,726	751	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 176,039	25

Facility Name &amp; ID Number

Sunset Rehabilitation &amp; Hlth C

# 0046094

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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		8	9	10					
		Related**					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	Bank of America		X	Mortgage	Varies	08/31/02	\$ 4,050,000	\$ 3,949,590	12/31/13	Varies	\$ 254,473	1				
2												2				
3							Interest Income Offset				(26)	3				
4							Home Office Allocation-PHC				4,621	4				
5												5				
	<b>Working Capital</b>															
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 4,050,000	\$ 3,949,590			\$ 259,068	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	\$ 3,949,590			\$ 259,068	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 the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>34,000</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.)	2007	\$	<b>32,153</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,847)</b>	3
4. Real Estate Tax accrual used for 2008 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>881</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>33,034</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>32,956</b>	8
	2004	<b>34,591</b>	9
	2005	<b>33,983</b>	10
	2006	<b>34,224</b>	11
	2007	<b>32,153</b>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>32,152.78</u>	\$ <u>32,152.78</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>32,152.78</u>	\$ <u>32,152.78</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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: 32,798 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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

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>41,382</u>	<u>2002</u>	<u>\$ 95,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>41,382</b>		<b>\$ 95,000</b>	<b>3</b>

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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	\$	30	\$ 77,167	\$ 77,167	\$ 501,585	4
5			2001	413,768		20	20,688	20,688	155,160	5
6	2		2003	148,271		20	7,414	7,414	40,777	6
7	8		2005	355,587		39	9,118	9,118	31,913	7
8										8
	<b>Improvement Type**</b>									
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	283	283	4,719	11
12	Petersen Properties Building Partnership		1994	1,780		15	119	119	1,745	12
13	Petersen Properties Building Partnership		1995	13,199		20	660	660	9,066	13
14										14
15	Field Audit		1990	1,102		15			1,102	15
16	Drapes		1995	8,206		20	410	410	5,467	16
17	Remodeling		1996	14,630		20	732	732	8,908	17
18	Awning		1996	1,105		20	55	55	665	18
19	Landscaping		1996	4,036		20	202	202	2,559	19
20	Back Taxes on Land		1996	531		20	27	27	290	20
21	Tiling		1997	500		20	25	25	275	21
22	Doors		1997	5,250		20	263	263	3,156	22
23	Tiling		1997	8,228		20	411	411	4,898	23
24	Gutters		1997	2,759		20	138	138	1,622	24
25	Landscaping		1997	1,886		20	94	94	1,105	25
26	Door Closer		1997	1,688		20	84	84	952	26
27	Concrete Slab		1997	1,440		20	72	72	840	27
28	Painting		1997	1,207		20	60	60	705	28
29	Furnace		1997	2,389		20	119	119	1,329	29
30	Awning		1997	4,077		20	204	204	2,346	30
31	Telephone System		1997	1,189		20	59	59	664	31
32	Roof/Windows		1998	36,145		20	1,807	1,807	18,974	32
33	Drapery		1998	1,402		20	70	70	735	33
34	Expansion Design		1998	3,639		20	182	182	1,911	34
35	Flooring/Cove Base		1998	619		20	31	31	326	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:

1/1/2008

Ending:

12/31/2008**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	\$ 171	37
38	Roof (Balance)	1999	1,000		20	50	50	475	38
39	Drapes	2000	1,966		20	98	98	833	39
40	Remove Trees	2000	1,072		20	54	54	459	40
41	Expansion	2000	1,945		20	97	97	829	41
42	Wood	2000	1,072		20	54	54	459	42
43	Land Work	2000	2,510		20	126	126	1,071	43
44	Flooring	2000	1,168		20	58	58	493	44
45	Shades	2001	1,788		20	89	89	668	45
46	Painting	2001	2,228		20	111	111	833	46
47	Carpet	2001	4,841		20	242	242	1,815	47
48	Carpet	2001	8,000		20	400	400	3,000	48
49	Painting	2001	345		20	17	17	128	49
50	Fire System	2001	42,286		20	2,114	2,114	15,855	50
51	Carpet	2001	2,155		20	108	108	810	51
52	Kitchen Remodeling	2001	43,315		20	2,166	2,166	16,245	52
53	Expansion	2002	7,352		20	368	368	2,394	53
54	Wall	2002	6,000		20	300	300	1,950	54
55	New Addition	2004	3,021		20	151	151	681	55
56	Stairway, sunroom, new addition	2004	218,275		20	10,914	10,914	49,113	56
57	Engineering Fees	2005	2,047		20	102	102	357	57
58	IDPH Planning Fee	2005	2,976		20	149	149	521	58
59	Architect Fees	2005	1,904		20	98	98	339	59
60	Asphalt West Lot	2006	21,480		20	1,074	1,074	2,864	60
61	Air Conditioner	2007	3,000		10	300	300	450	61
62	Wheelchair Ramp	2007	930		15	62	62	93	62
63	Fencing	2008	3,634		39	47	47	47	63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,757,559	\$		\$ 139,861	\$ 139,861	\$ 923,291	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 3,757,559	\$		\$ 139,861	\$ 139,861	\$ 923,291	1
2								2
3								3
4								4
5								5
6			59,359			(59,359)		6
7			35,379			(35,379)		7
8								8
9								9
10								10
11		1,206			78	78		11
12		18,031			432	432		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		\$ 3,776,796	\$ 94,738		\$ 140,371	\$ 45,633	\$ 923,291	34

\*\*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:

1/1/2008

Ending:

12/31/2008

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	\$ 376,739	\$ 10,820	\$ 37,836	\$ 27,016	7-10 yrs.	\$ 364,675	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	165,723					165,723	73
74	Home Office Allocation			6,569	6,569			74
75	TOTALS	\$ 542,462	\$ 10,820	\$ 44,405	\$ 33,585		\$ 530,398	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	908		(908)	4	17,143	79
80	TOTALS			\$ 139,290	\$ 2,583	\$	\$ (2,583)		\$ 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)	\$ 4,553,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 108,141	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 184,776	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 76,635	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,592,979	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				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.

Facility Name & ID Number

Sunset Rehabilitation & Hlth C

# 0046094

Report Period Beginning:

1/1/2008

Ending: 12/31/2008

**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								6
7	TOTAL				\$			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: \$ 5,947 Description: See Attached 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	Facility	2007 Ford Van	\$ 1,831	\$ 21,970	17
18					18
19					19
20					20
21	TOTAL		\$ 1,831	\$ 21,970	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.

**Sunset Manor**

**Period Beginning**                      **1/1/2008**  
**Period End**                                **12/31/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$	587
Copier		4,609
Home Office Allocation		751
		<u>5,947</u>
		<u><u>5,947</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	10A(3)	hrs	\$	11,923	\$ 178,850	\$	11,923	\$ 178,850	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,113	16,700		1,113	16,700	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		11,797	176,951	25	11,797	176,976	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				74,478		74,478	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>			\$	24,833	\$ 372,501	\$ 74,503	24,833	\$ 447,004	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 &amp; ID Number      Sunset Rehabilitation &amp; Hlth C

#      0046094

Report Period Beginning:      1/1/2008

Ending:      12/31/2008

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

As of      12/31/2008

(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	\$ 2,363,525	\$ 2,363,525	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	1,050,603	1,050,603	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,517	28,517	6
7	Other Prepaid Expenses	15,449	15,449	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	10,779	10,779	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,468,873	\$ 3,468,873	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	3,250,657	14
15	Leasehold Improvements, at Historical Cost	964,512	526,139	15
16	Equipment, at Historical Cost	697,872	681,752	16
17	Accumulated Depreciation (book methods)	(1,269,503)	(1,592,979)	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): <u>                    </u>			22
23	Other(specify): <u>Goodwill</u>	1,790,000	1,790,000	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 5,056,670	\$ 4,750,569	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 8,525,543	\$ 8,219,442	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 602,214	\$ 602,214	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,116	117,116	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,571	3,571	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,000	34,000	32
33	Accrued Interest Payable	23,265	23,265	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	36,682	36,682	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 816,848	\$ 816,848	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,949,590	3,949,590	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</b> (sum of lines 39 thru 44)	\$ 3,949,590	\$ 3,949,590	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,766,438	\$ 4,766,438	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,759,105	\$ 3,453,004	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 8,525,543	\$ 8,219,442	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>3,312,640</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(1)</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>3,312,639</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>446,466</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>446,466</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>3,759,105</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	\$ 3,515,495	1
2	Discounts and Allowances for all Levels	80,440	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,595,935	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	539,123	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 539,123	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	3,218	14
15	Telephone, Television and Radio	330	15
16	Rental of Facility Space		16
17	Sale of Drugs	119,460	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,938	20
21	Other Medical Services	2,740	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 128,686	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	26	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 26	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	2,059	28
28a	Meals on Wheels Revenue	43,487	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 45,546	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,309,316	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	879,310	31
32	Health Care	1,893,094	32
33	General Administration	398,943	33
	<b>B. Capital Expense</b>		
34	Ownership	422,790	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	205,577	35
36	Provider Participation Fee	63,136	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,862,850	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	446,466	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 446,466	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 part of 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.

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

# **0046094**

Report Period Beginning:

**1/1/2008**

Ending:

**12/31/2008**

**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	1,979	2,126	\$ 59,708	\$ 28.08	1
2	Assistant Director of Nursing	1,820	1,820	36,622	20.12	2
3	Registered Nurses	4,096	4,193	90,219	21.52	3
4	Licensed Practical Nurses	19,868	20,531	398,208	19.40	4
5	CNAs & Orderlies	66,788	68,843	656,929	9.54	5
6	CNA Trainees					6
7	Licensed Therapist	10	10	134	13.40	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	21,357	10.27	9
10	Activity Assistants	1,817	1,817	16,241	8.94	10
11	Social Service Workers	1,804	1,804	27,061	15.00	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,198	11.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,063	14,763	122,940	8.33	15
16	Dishwashers					16
17	Maintenance Workers	4,230	4,230	46,810	11.07	17
18	Housekeepers	19,257	20,256	180,645	8.92	18
19	Laundry	4,556	4,679	37,272	7.97	19
20	Administrator	2,080	2,080	55,675	26.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,031	2,031	18,374	9.05	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. PG20A</u>	6,031	6,094	109,798	18.02	33
34	TOTAL (lines 1 - 33)	154,590	159,437	\$ 1,901,191 *	\$ 11.92	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	13 HRS.	\$ 735	9(3)	35
36	Medical Director	Monthly	22,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,435		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 1/1/2008

Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,788	3,788	78,243	20.66
Marketing	457	457	7,781	17.03
Transportation	1,179	1,242	10,802	8.70
Restorative Nurse	607	607	12,972	21.37
<b>TOTAL (lines 1 - 35)</b>	<b>6,031</b>	<b>6,094</b>	<b>109,798</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	\$ 55,675	Workers' Compensation Insurance	\$ 65,510	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	28,880	Advertising: Employee Recruitment	308		
				FICA Taxes	145,164	Health Care Worker Background Check			
				Employee Health Insurance	13,469	(Indicate # of checks performed )			
				Employee Meals		Patient Background Checks	240		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,108		
				Employee Relations	2,809	Miscellaneous Dues & Subscriptions	324		
				Employee Retirement	2,676	IHCA Dues	4,440		
				Employee Life Insurance	71	Home Office Allocation	1,673		
						CMS Revisit Fee	2,072		
						Less: Public Relations Expense	(324)		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,675	TOTAL (agree to Schedule V, line 22, col.8)		\$ 258,579	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 13,991
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense		
							Home Office Allocation	367	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,005	TOTAL		\$	TOTAL	\$ 367	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Sunset Rehabilitation & Hlth C****0046094****Period Beginning 1/1/2008****Period End 12/31/2008****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)		5,005

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	197
GoffWilson, P.A.	Legal	658
Ginoli & Company	Accountants	1,599
RSM McGladrey	Accountants	15
Miscellaneous Vendors	Computer Services	77
Emdeon Business Services	Computer Services	106
Advanced Answers on Demand	Computer Services	1,246
Access 2 Go	Computer Services	368
Ivans	Computer Services	191
Kemper Technology	Computer Services	675
VisionShare	Computer Services	72
Logmein	Computer Services	52
Comm Net Communiations	Computer Services	19
Charter Communications	Computer Services	16
Advanced System Designs	Computer Services	24
Consolidated Communications	Computer Services	15
Miscellaneous Vendors	Miscellaneous	93

Total (agree to Schedule V, line 19, column 8)	<u>10,428</u>
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**Sunset Rehabilitation & Hlth C**

**0046094**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<u>Name</u>	<u>Ownership %</u>	<u>Amount</u>
Margaret Ferris	0	55,675
	<b>Total</b>	<u><u>55,675</u></u>



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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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. 4,440 -IHCA
- (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? No
- (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. \$ 19,089 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? N/A  
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. \$ 63,136  
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. \$ 46,705
- (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. \$ No
- 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? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company 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