

Facility Name & ID Number Sunset Rehab & Hlth C

0046094 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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>9,125</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>90</u>	Intermediate (ICF)	<u>90</u>	<u>32,850</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>41,975</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>1,918</u>	<u>1,918</u>	8
9	SNF/PED					9
10	ICF	<u>23,989</u>	<u>3,709</u>	<u>393</u>	<u>28,091</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,989</u>	<u>3,709</u>	<u>2,311</u>	<u>30,009</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.49%

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

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 8/1/1990

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

YES Date 8/1/1990 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 1,918

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Sunset Rehab & Hlth C

0046094

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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
	A. General Services										
1	Dietary	153,523	17,742	1,147	172,412		172,412	5,913	178,325		1
2	Food Purchase		224,191		224,191		224,191	(38,941)	185,250		2
3	Housekeeping	226,581	30,160		256,741		256,741	59	256,800		3
4	Laundry	7,873	15,552		23,425		23,425		23,425		4
5	Heat and Other Utilities			100,839	100,839		100,839	449	101,288		5
6	Maintenance	30,078	12,697	32,775	75,550		75,550	2,897	78,447		6
7	Other (specify):* Home Off. Ben. All.							334	334		7
8	TOTAL General Services	418,055	300,342	134,761	853,158		853,158	(29,289)	823,869		8
	B. Health Care and Programs										
9	Medical Director			19,000	19,000		19,000		19,000		9
10	Nursing and Medical Records	1,353,940	61,936	8,823	1,424,699		1,424,699	(543)	1,424,156		10
10a	Therapy		116	271,078	271,194		271,194		271,194		10a
11	Activities	43,360	204	404	43,968		43,968	(3,509)	40,459		11
12	Social Services	18,289			18,289		18,289		18,289		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,415,589	62,256	299,305	1,777,150		1,777,150	(4,052)	1,773,098		16
	C. General Administration										
17	Administrative			78,000	78,000		78,000	(29,021)	48,979		17
18	Directors Fees										18
19	Professional Services			6,801	6,801		6,801	12,467	19,268		19
20	Dues, Fees, Subscriptions & Promotions			7,817	7,817		7,817	106	7,923		20
21	Clerical & General Office Expenses	25,700	6,320	186,053	218,073		218,073	73,080	291,153		21
22	Employee Benefits & Payroll Taxes			291,810	291,810		291,810		291,810		22
23	Inservice Training & Education			800	800		800	118	918		23
24	Travel and Seminar							6	6		24
25	Other Admin. Staff Transportation			8,573	8,573		8,573	5,474	14,047		25
26	Insurance-Prop.Liab.Malpractice			43,011	43,011		43,011	1,057	44,068		26
27	Other (specify):* Home Off. Ben. All.							6,783	6,783		27
28	TOTAL General Administration	25,700	6,320	622,865	654,885		654,885	70,070	724,955		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,859,344	368,918	1,056,931	3,285,193		3,285,193	36,729	3,321,922		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 Rehab & Hlth C

#0046094

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	
	D. Ownership											
30	Depreciation			105,388	105,388		105,388	50,672	156,060			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,469	111,469		111,469	(10,773)	100,696			32
33	Real Estate Taxes			39,330	39,330		39,330	476	39,806			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,808	18,808		18,808	876	19,684			35
36	Other (specify):*											36
37	TOTAL Ownership			274,995	274,995		274,995	41,251	316,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,736		81,736		81,736		81,736			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			233,560	233,560		233,560		233,560			42
43	Other (specify):* Non-allowable Costs	27,287	2,390	143,303	172,980		172,980	(172,980)				43
44	TOTAL Special Cost Centers	27,287	84,126	376,863	488,276		488,276	(172,980)	315,296			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,886,631	453,044	1,708,789	4,048,464		4,048,464	(95,000)	3,953,464			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	(7,652)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,867)	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	45,814	30		9
10	Interest and Other Investment Income	(18,854)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	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	(47,212)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,439)	43		24
25	Fund Raising, Advertising and Promotional	(30,959)	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 Page 5A	(42,691)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (190,051)		\$	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)	95,051	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 95,051		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (95,000)		37

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

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

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

Sunset Rehab & Hlth C

ID# 0046094

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (3,893)	43	1
2	X-Rays-Part A	(2,263)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(204)	21	3
4	Resident Flowers	(38)	43	4
5	Offset Chamber of Commerce Dues	(687)	20	5
6	Offset Meals on Wheels Revenue	(31,415)	2	6
7	Disallowed Special Events	(78)	43	7
8	Offset Cable TV Revenue	(40)	43	8
9	Offset Miscellaneous Nursing Supplies-General	(564)	10	9
10	Offset Transportation Revenue	(3,509)	11	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	Total		(42,691)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	5,913	0	0	0	0	0	0	0	0	0	5,913	1
2	Food Purchase	(31,415)	126	0	0	0	0	0	0	0	0	0	(31,289)	2
3	Housekeeping	0	59	0	0	0	0	0	0	0	0	0	59	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	449	0	0	0	0	0	0	0	0	0	449	5
6	Maintenance	0	2,897	0	0	0	0	0	0	0	0	0	2,897	6
7	Other (specify):*	0	334	0	0	0	0	0	0	0	0	0	334	7
8	TOTAL General Services	(31,415)	9,778	0	0	0	0	0	0	0	0	0	(21,637)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(564)	21	0	0	0	0	0	0	0	0	0	(543)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,509)	0	0	0	0	0	0	0	0	0	0	(3,509)	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	TOTAL Health Care and Programs	(4,073)	21	0	0	0	0	0	0	0	0	0	(4,052)	16
	C. General Administration													
17	Administrative	0	(29,021)	0	0	0	0	0	0	0	0	0	(29,021)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,467	0	0	0	0	0	0	0	0	0	12,467	19
20	Fees, Subscriptions & Promotions	(687)	0	793	0	0	0	0	0	0	0	0	106	20
21	Clerical & General Office Expenses	(204)	0	73,284	0	0	0	0	0	0	0	0	73,080	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	118	0	0	0	0	0	0	0	0	118	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	5,474	0	0	0	0	0	0	0	0	5,474	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,057	0	0	0	0	0	0	0	0	1,057	26
27	Other (specify):*	0	0	6,783	0	0	0	0	0	0	0	0	6,783	27
28	TOTAL General Administration	(891)	(16,554)	87,515	0	70,070	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,379)	(6,755)	87,515	0	44,381	29							

STATE OF ILLINOIS

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

Report Period Beginning:

1/1/2013 Ending:

Summary B

12/31/2013

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)	
	D. Ownership													
30	Depreciation	(7,867)	0	4,858	0	0	0	0	0	0	0	0	(3,009)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8,081	0	0	0	0	0	0	0	0	8,081	32
33	Real Estate Taxes	0	0	476	0	0	0	0	0	0	0	0	476	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	876	0	0	0	0	0	0	0	0	876	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,867)	0	14,291	0	6,424	37							
	Ancillary Expense													
	E. Special Cost Centers													
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):*	39,502	0	0	0	0	0	0	0	0	0	0	39,502	43
44	TOTAL Special Cost Centers	39,502	0	0	0	0	0	0	0	0	0	0	39,502	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(4,744)	(6,755)	101,806	0	0	0	0	0	0	0	0	90,307	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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%	\$ 5,913	\$ 5,913	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	126	126	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	59	59	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	449	449	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,897	2,897	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	334	334	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	21	21	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	78,000	Petersen Health Care, Inc.	100.00%	48,979	(29,021)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	12,467	12,467	12
13	V							13
14	Total		\$ 78,000			\$ 71,245	\$ * (6,755)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 793	\$	793	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	73,284		73,284	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	118		118	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	6		6	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	5,474		5,474	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,057		1,057	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,783		6,783	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,858		4,858	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,081		8,081	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	476		476	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	876		876	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 101,806	\$ *	101,806	39

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

Facility Name & ID Number

Sunset Rehab & Hlth C

0046094

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Sunset Rehab & Hlth C

0046094

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Sunset Rehab & Hlth C

0046094

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Sunset Rehab & Hlth C

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Report Period Beginning:

1/1/2013

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12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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

Facility Name & ID Number

Sunset Rehab & Hlth C

#

0046094

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

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

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

Facility Name & ID Number Sunset Rehab & Hlth C

0046094

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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	1,560,986	75	\$ 307,592	\$ 295,212	30,009	\$ 5,913	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	30,009	126	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	30,009	59	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	30,009	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	30,009	449	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	30,009	2,897	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	30,009	334	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	30,009	21	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	30,009	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	30,009	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	30,009	48,979	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	30,009	12,467	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	30,009	793	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	30,009	73,284	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	30,009	118	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	30,009	6	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	30,009	5,474	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	30,009	1,057	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	30,009	6,783	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	30,009	4,858	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	30,009	8,081	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	30,009	476	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	30,009	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	30,009	876	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 173,051	25

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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	11						
		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			
A. Directly Facility Related																		
Long-Term																		
1	Bank of America		X	Mortgage	Varies	08/31/02	\$ 4,050,000	\$ 3,334,831	12/31/13	Varies	\$ 111,469	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,050,000	\$ 3,334,831			\$ 111,469	9						
B. Non-Facility Related*																		
10											(18,854)	10						
11											8,081	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(10,773)	14						
15	TOTALS (line 9+line14)						\$ 4,050,000	\$ 3,334,831			\$ 100,696	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

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

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

B. Real Estate Taxes

		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 2012 report.			\$ 39,312	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.)	2012		\$ 38,742	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ (570)	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 39,900	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			\$ 476		
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Home Office Allocation	476	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 39,806	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>32,901</u>	8		
	2009	<u>34,773</u>	9		
	2010	<u>35,928</u>	10		
	2011	<u>38,164</u>	11		
	2012	<u>38,742</u>	12		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2012 \$ 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.

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

If YES, attach an explanation and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>41,382</u>	<u>2002</u>	<u>\$ 95,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	41,382		\$ 95,000	3

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 887,420	4
5			2001	413,768		20	20,688	20,688	258,600	5
6	2		2003	148,271		20	7,414	7,414	77,847	6
7	8		2005	355,587		39	9,118	9,118	77,503	7
8										8
	Improvement Type**									
9	Petersen Properties Building Partnership		1990	6,417		15			6,417	9
10	Petersen Properties Building Partnership		1991	10,127		15			10,127	10
11	Petersen Properties Building Partnership		1993	4,719		15			4,719	11
12	Petersen Properties Building Partnership		1994	1,780		15			1,780	12
13	Petersen Properties Building Partnership		1995	13,199		20	660	660	12,366	13
14										14
15	Field Audit		1990	1,102		15			1,102	15
16	Drapes		1995	8,206		20	410	410	7,517	16
17	Remodeling		1996	14,630		20	732	732	12,568	17
18	Awning		1996	1,105		20	55	55	940	18
19	Landscaping		1996	4,036		20	202	202	3,569	19
20	Back Taxes on Land		1996	531		20	27	27	425	20
21	Tiling		1997	500		20	25	25	400	21
22	Doors		1997	5,250		20	263	263	4,471	22
23	Tiling		1997	8,228		20	411	411	6,953	23
24	Gutters		1997	2,759		20	138	138	2,312	24
25	Landscaping		1997	1,886		20	94	94	1,575	25
26	Door Closer		1997	1,688		20	84	84	1,372	26
27	Concrete Slab		1997	1,440		20	72	72	1,200	27
28	Painting		1997	1,207		20	60	60	1,005	28
29	Furnace		1997	2,389		20	119	119	1,924	29
30	Awning		1997	4,077		20	204	204	3,366	30
31	Telephone System		1997	1,189		20	59	59	959	31
32	Roof/Windows		1998	36,145		20	1,807	1,807	28,009	32
33	Drapery		1998	1,402		20	70	70	1,085	33
34	Expansion Design		1998	3,639		20	182	182	2,821	34
35	Flooring/Cove Base		1998	619		20	31	31	481	35
36										36

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

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

See Page 12A, Line 70 for total

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XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 261	37
38	Roof (Balance)	1999	1,000		20	50	50	725	38
39	Drapes	2000	1,966		20	98	98	1,323	39
40	Remove Trees	2000	1,072		20	54	54	729	40
41	Expansion	2000	1,945		20	97	97	1,314	41
42	Wood	2000	1,072		20	54	54	729	42
43	Land Work	2000	2,510		20	126	126	1,701	43
44	Flooring	2000	1,168		20	58	58	783	44
45	Shades	2001	1,788		20	89	89	1,113	45
46	Painting	2001	2,228		20	111	111	1,388	46
47	Carpet	2001	4,841		20	242	242	3,025	47
48	Carpet	2001	8,000		20	400	400	5,000	48
49	Painting	2001	345		20	17	17	213	49
50	Fire System	2001	42,286		20	2,114	2,114	26,425	50
51	Carpet	2001	2,155		20	108	108	1,350	51
52	Kitchen Remodeling	2001	43,315		20	2,166	2,166	27,075	52
53	Expansion	2002	7,352		20	368	368	4,234	53
54	Wall	2002	6,000		20	300	300	3,450	54
55	New Addition	2004	3,021		20	151	151	1,436	55
56	Stairway, sunroom, new addition	2004	218,275		20	10,914	10,914	103,683	56
57	Engineering Fees	2005	2,047		20	102	102	867	57
58	IDPH Planning Fee	2005	2,976		20	149	149	1,266	58
59	Architect Fees	2005	1,904		20	98	98	829	59
60	Asphalt West Lot	2006	21,480		20	1,074	1,074	8,234	60
61	Air Conditioner	2007	3,000		10	300	300	1,950	61
62	Wheelchair Ramp	2007	930		15	62	62	403	62
63	Fencing	2008	3,634		39	94	94	517	63
64	Generator Repair	2009	3,214		7	460	460	2,070	64
65	Boiler and Mixing Valve Repair	2009	5,449		7	778	778	3,501	65
66	Boiler Repair	2009	2,582		7	368	368	1,656	66
67	Air Conditioner-Dining Room	2009	3,834		7	548	548	2,466	67
68	Roof Installation	2009	6,752		15	450	450	2,025	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,779,390	\$		\$ 142,110	\$ 142,110	\$ 1,632,574	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,779,390	\$		\$ 142,110	\$ 142,110	\$ 1,632,574	1
2	Sunroom	2009	10,779		35	308	308	1,386	2
3	Water Heater	2010	6,518		7	932	932	3,262	3
4	Air Conditoner Repair	2010	3,308		7	472	472	1,652	4
5	Boiler	2010	14,000		20	700	700	2,450	5
6	Boiler	2012	22,000		15	1,466	1,466	2,199	6
7	Carpeting-Lobby, A Wing, Medium Wing, Alzheimers Hall	2013	36,269		15	1,209	1,209	1,209	7
8	Furnace and Air Conditoner	2013	6,920		15	231	231	231	8
9	Boilers	2013	23,500		15	783	783	783	9
10	Roof Repair	2013	5,369		7	384	384	384	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	Land Improvements Booked			179			(179)		25
26	Building Booked			73,687			(73,687)		26
27	Building Improvements Booked			29,059			(29,059)		27
28									28
29									29
30	2013-Home Office Allocation-Building Improvements		14,110			338	338		30
31	2013-Home Office Allocation-Land Improvements		1,317			84	84		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,923,480	\$ 102,925		\$ 149,017	\$ 46,092	\$ 1,646,130	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 23,030	\$ 1,996	\$ 2,252	\$ 256	5-10 yrs.	\$ 13,151	71
72	Current Year Purchases	7,089	467	355	(112)	10 yrs.	355	72
73	Fully Depreciated Assets	308,056					308,056	73
74	Home Office Allocation			4,436	4,436			74
75	TOTALS	\$ 338,175	\$ 2,463	\$ 7,043	\$ 4,580		\$ 321,562	75

D. Vehicle Costs. (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	2001 Dodge Caravan	2001	47,863	\$	\$	\$		\$ 47,863	76
77	Facility	2001 Chevy	2002	17,143					17,143	77
78										78
79										79
80	TOTALS			\$ 65,006	\$	\$	\$		\$ 65,006	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)	\$ 4,421,661	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,388	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 156,060	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 50,672	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,032,698	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Elevator Replacement	\$ 60,295	92
93			93
94			94
95		\$ 60,295	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 Rehab & Hlth C

0046094

Report Period Beginning:

1/1/2013

Ending: 12/31/2013

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 12,746 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	2012 Ford E250	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Sunset Rehab & Hlth C

0046094

Period Beginning 1/1/2013

Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	5,773
Dishwasher		1,074
Laundry Equipment		-
Copier		5,023
Home Office Allocation		876
		<u>12,746</u>

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	8,270	\$ 124,050	\$	8,270	\$ 124,050	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		862	12,924		862	12,924	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,940	134,104	116	8,940	134,220	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 prescrpts				81,736		81,736	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	TOTAL			\$	18,072	\$ 271,078	\$ 81,852	18,072	\$ 352,930	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 Rehab & Hlth C# 0046094Report Period Beginning: 1/1/2013Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,171,026	\$ 4,171,026	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>147,359</u>)	804,600	804,600	3
4	Supply Inventory (priced at)	15,021	15,021	4
5	Short-Term Investments			5
6	Prepaid Insurance	40,219	40,219	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	5,466	5,466	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,036,332	\$ 5,036,332	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	177,687	95,000	13
14	Buildings, at Historical Cost	2,873,789	3,246,736	14
15	Leasehold Improvements, at Historical Cost	937,320	676,744	15
16	Equipment, at Historical Cost	396,092	403,181	16
17	Accumulated Depreciation (book methods)	(1,474,971)	(2,032,698)	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 (spec <u>Cons. In Progress</u>)	60,295	60,295	22
23	Other(specify): <u>Goodwill</u>	1,790,000	1,790,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,760,212	\$ 4,239,258	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,796,544	\$ 9,275,590	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 857,029	\$ 857,029	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,571	113,571	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,006	8,006	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,900	39,900	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	99,451	99,451	36
37	<u>Accrued Management Fees</u>	50,565	50,565	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,168,522	\$ 1,168,522	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,334,831	3,334,831	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	662,961	662,961	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,997,792	\$ 3,997,792	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,166,314	\$ 5,166,314	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,630,230	\$ 4,109,276	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,796,544	\$ 9,275,590	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,702,887	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,702,887	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(72,657)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (72,657)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,630,230	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunset Rehab & Hlth C# 0046094Report Period Beginning: 1/1/2013Ending: 12/31/2013

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,667,459	1
2	Discounts and Allowances for all Levels	(365,695)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,301,764	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	479,085	6
7	Oxygen	1,809	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 480,894	8
C. Other Operating Revenue			
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	7,652	14
15	Telephone, Television and Radio	40	15
16	Rental of Facility Space		16
17	Sale of Drugs	125,191	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,244	20
21	Other Medical Services	2,476	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 138,603	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	18,854	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,854	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous and Transportation Revenue	4,277	28
28a	Meals on Wheels Revenue	31,415	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35,692	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,975,807	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	853,158	31
32	Health Care	1,777,150	32
33	General Administration	654,885	33
B. Capital Expense			
34	Ownership	274,995	34
C. Ancillary Expense			
35	Special Cost Centers	254,716	35
36	Provider Participation Fee	233,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,048,464	40
41	Income before Income Taxes (line 30 minus line 40)**	(72,657)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (72,657)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,329,898	44
45	Private Pay - Net Inpatient Revenue	620,952	45
46	Medicare - Net Inpatient Revenue	355,791	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(4,877)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,301,764	49

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

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

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

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

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

0046094

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 66,313	\$ 31.88	1
2	Assistant Director of Nursing	1,907	1,907	49,051	25.72	2
3	Registered Nurses	5,606	5,666	129,841	22.92	3
4	Licensed Practical Nurses	18,059	18,780	398,142	21.20	4
5	CNAs & Orderlies	54,780	56,246	615,776	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,788	1,920	22,041	11.48	9
10	Activity Assistants	541	541	5,011	9.26	10
11	Social Service Workers	1,554	1,652	18,289	11.07	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,250	12.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,869	13,352	128,273	9.61	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	30,078	14.46	17
18	Housekeepers	22,406	23,317	226,581	9.72	18
19	Laundry	944	944	7,873	8.34	19
20	Administrator	2,080	2,080	48,979	23.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,992	2,098	25,700	12.25	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 PG20A</u>	7,434	7,565	138,412	18.30	33
34	TOTAL (lines 1 - 33)	138,200	142,308	\$ 1,935,610 *	\$ 13.60	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	23	\$ 1,147	L1, C3	35
36	Medical Director	Monthly	19,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,088	L10, C3	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)	23	\$ 26,235		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 Rehab & Hlth C

0046094

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,136	2,216	48,012	21.67
Restorative Nurse	2,080	2,080	46,805	22.50
Transportation	1,515	1,566	16,308	10.41
Marketing	1,703	1,703	27,287	16.02
TOTAL	<u>7,434</u>	<u>7,565</u>	<u>138,412</u>	

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	
Brian Anderson	Administrator	0	\$ 28,269	Workers' Compensation Insurance	\$ 57,753	IDPH License Fee	\$ 5,170	
Michelle Hansmeyer	Administrator	0	20,710	Unemployment Compensation Insurance	45,590	Advertising: Employee Recruitment	656	
				FICA Taxes	149,216	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	34,498	Patient Background Checks	130	
				Employee Meals		Miscellaneous Licenses & Permits	(2)	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	687	
				Employee Relations	2,836	Home Office Allocation	793	
				Employee Retirement	1,917			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,979	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,923		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(687)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 78,000				Non-allowable advertising	
							()	
							Yellow page advertising	
							()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 78,000				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Allscripts	Computer Services		\$ 1,673				Out-of-State Travel	\$
Comcast	Computer Services		1,938					
Honkamp Krueger & Co.	Accounting Fees		500					
CEFCU	Legal Services		190	N/A			In-State Travel	
Consolidated Land Survey	Surveying Fees		2,500					
							Seminar Expense	
							Home Office Allocation	6
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,801	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 6	

* Attach copy of IMRF notifications

**See instructions.

Sunset Rehab & Hlth C

0046094

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,801
Home Office Allocation		
SmithAmundsen	Legal	741
Cole, Schotz, Meisel	Legal	408
Black, Hedin, Ballard	Legal	37
Ginoli & Company	Accountants	1350
Miscellaneous	Computer Services	115
Odessian LLC	Computer Services	58
CCH	Computer Services	17
Lexis-Nexis	Computer Services	7
Ipanema Solutions	Computer Services	16
Macquarie Technology Services	Computer Services	106
Advanced Answers on Demand	Computer Services	5487
TeamViewer	Computer Services	18
Stratus Networks	Computer Services	443
Kemper Technology	Computer Services	342
AT&T	Computer Services	6
Medifax	Computer Services	50
Vision Share/Ability Network	Computer Services	751
Barracuda	Computer Services	135
CIAN	Computer Services	180
Comcast	Computer Services	40
Emdeon	Computer Services	60
Marotta Gund Budd & Dzera	Other Prof Fees	1679
David Budde	Other Prof Fees	35
Pharmacy Price Mangement	Other Prof Fees	139
All Scripts	Other Prof Fees	247

Total (agree to Schedule V, line 19, column 8)

19,268

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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

Report Period Beginning:

1/1/2013

Ending:

12/31/2013**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? No
If YES, give association name and amount. _____
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,777 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 233,560
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. \$ 7,652
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 3,509
- 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? 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: Ginoli & Company
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.