

		FOR BHF USE					

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**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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

<p><b>I. IDPH License ID Number:</b> <u>0052993</u></p> <p><b>Facility Name:</b> <u>Sunset Rehabilitation &amp; HC</u></p> <p><b>Address:</b> <u>129 South 1st Avenue</u> <u>Canton</u> <u>61520</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Fulton</u></p> <p><b>Telephone Number:</b> <u>(309) 674-4327</u> <b>Fax #</b> <u>(309) 674-4354</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>08/01/1990</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Mark B. Petersen</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # <u>( )</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630         </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name & ID Number Sunset Rehabilitation & HC

# 0052993 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF		<u>5,272</u>	<u>1,784</u>	<u>7,056</u>	8
9	SNF/PED					9
10	ICF	<u>21,848</u>		<u>670</u>	<u>22,518</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,848</u>	<u>5,272</u>	<u>2,454</u>	<u>29,574</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.46%

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 1,784

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: 12/31/14 Fiscal Year: 12/31/14

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

**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	162,674	17,137	399	180,210		180,210	9,996	190,206		1
2	Food Purchase		235,733		235,733		235,733	(46,156)	189,577		2
3	Housekeeping	216,332	31,947		248,279		248,279	61	248,340		3
4	Laundry	24,028	17,965		41,993		41,993		41,993		4
5	Heat and Other Utilities			107,565	107,565		107,565	376	107,941		5
6	Maintenance	32,959	5,910	30,024	68,893		68,893	3,758	72,651		6
7	Other (specify):* Home Off. Ben. All.										7
8	<b>TOTAL General Services</b>	<b>435,993</b>	<b>308,692</b>	<b>137,988</b>	<b>882,673</b>		<b>882,673</b>	<b>(31,965)</b>	<b>850,708</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,500	16,500		16,500	35	16,535		9
10	Nursing and Medical Records	1,332,930	77,240	13,118	1,423,288		1,423,288	(226)	1,423,062		10
10a	Therapy			314,259	314,259		314,259		314,259		10a
11	Activities	50,982	154	323	51,459		51,459	(4,531)	51,459		11
12	Social Services	24,658			24,658		24,658		24,658		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,408,570</b>	<b>77,394</b>	<b>344,200</b>	<b>1,830,164</b>		<b>1,830,164</b>	<b>(4,722)</b>	<b>1,829,973</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			127,600	127,600		127,600	(70,266)	57,334		17
18	Directors Fees										18
19	Professional Services			8,445	8,445		8,445	12,237	20,682		19
20	Dues, Fees, Subscriptions & Promotions			11,136	11,136		11,136	(320)	10,816		20
21	Clerical & General Office Expenses	26,323	5,725	9,815	41,863		41,863	110,683	152,546		21
22	Employee Benefits & Payroll Taxes			277,573	277,573		277,573	23,589	301,162		22
23	Inservice Training & Education			99	99		99	45	144		23
24	Travel and Seminar							38	38		24
25	Other Admin. Staff Transportation			14,334	14,334		14,334	6,069	20,403		25
26	Insurance-Prop.Liab.Malpractice			36,780	36,780		36,780	5,106	41,886		26
27	Other (specify):* Home Off. Ben. All.										27
28	<b>TOTAL General Administration</b>	<b>26,323</b>	<b>5,725</b>	<b>485,782</b>	<b>517,830</b>		<b>517,830</b>	<b>87,181</b>	<b>605,011</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,870,886</b>	<b>391,811</b>	<b>967,970</b>	<b>3,230,667</b>		<b>3,230,667</b>	<b>50,494</b>	<b>3,285,692</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; HC

#0052993

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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			81,037	81,037	81,037	49,854	130,891				30
31	Amortization of Pre-Op. & Org.						2,155	2,155				31
32	Interest			75,776	75,776	75,776	28,024	103,800				32
33	Real Estate Taxes			30,770	30,770	30,770	10,615	41,385				33
34	Rent-Facility & Grounds			83,012	83,012	83,012	(83,012)					34
35	Rent-Equipment & Vehicles			32,241	32,241	32,241	1,479	33,720				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			302,836	302,836	302,836	9,115	311,951				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,601		51,601	51,601		51,601				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			242,112	242,112	242,112		242,112				42
43	Other (specify):*	30,000	2,010	251,281	283,291	283,291	(283,291)					43
44	<b>TOTAL Special Cost Centers</b>	30,000	53,611	493,393	577,004	577,004	(283,291)	293,713				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,900,886	445,422	1,764,199	4,110,507	4,110,507	(223,682)	3,891,356				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	(6,033)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,367)	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	12,052	30		9
10	Interest and Other Investment Income	(1,904)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(641)	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	(114,153)	43		18
19	Entertainment				19
20	Contributions	(550)	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	(120,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,898)	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	(83,551)	various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (325,045)		\$	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)	101,363	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 101,363		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (223,682)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Sunset Rehabilitation & HC

ID# 0052993

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (3,641)	43	1
2	X-Rays-Part A	(1,362)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(247)	21	3
4	Resident Flowers		43	4
5	Offset Chamber of Commerce Dues	(597)	20	5
6	Offset Meals on Wheels Revenue	(40,240)	2	6
7	Disallowed Special Events	(669)	43	7
8	Offset Marketing Expense	(32,010)	43	8
9	Offset Miscellaneous Nursing Supplies-General	(254)	10	9
10	Offset Transportation Revenue	(4,531)	11	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(83,551)	49

**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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,354	\$ 4,354	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	104	104	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	294	294	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,652	1,652	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	35	35	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	8
9	V	10A TherBXY		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		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,755	3,755	12
13	V							13
14	Total		\$			\$ 10,217	\$ * 10,217	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 <u>Dues, Fees, Subs &amp; Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 209	\$	209	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	49,010		49,010	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,228		2,228	17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	25		25	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	15		15	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,963		3,963	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	699		699	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		0	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4,003		4,003	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,545		2,545	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	197		197	25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,007		1,007	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 63,901	\$ *	63,901	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$		100.00%	\$ 5,642	\$ 5,642
16	V	2 Food			100.00%	13	13
17	V	3 Housekeeping			100.00%	39	39
18	V	5 Utilities			100.00%	82	82
19	V	6 Maintenance			100.00%	2,106	2,106
20	V	7 Mgmt. Allocation of Benefits			100.00%	0	
21	V	9 Medical Director			100.00%	0	
22	V	10 Nursing and Medical Records			100.00%	27	27
23	V	10A TherBXy			100.00%	0	
24	V	15 Mgmt. Allocation of Benefits			100.00%	0	
25	V	17 Administrative	127,600		100.00%	57,334	(70,266)
26	V	19 Professional Services			100.00%	8,482	8,482
27	V	20 Dues, Fees, Subs & Promotions			100.00%	68	68
28	V	21 Clerical and General Office			100.00%	61,920	61,920
29	V	22 Employee Benefits and Payroll Taxes			100.00%	21,361	21,361
30	V	23 Inservice Training & Education			100.00%	20	20
31	V	24 Travel and Seminar			100.00%	23	23
32	V	25 Other Admin. Staff Transport.			100.00%	2,106	2,106
33	V	26 Insurance-Prop./Liab./Malprac.			100.00%	177	177
34	V	27 Mgmt. Allocation of Benefits			100.00%	0	
35	V	30 Depreciation			100.00%	271	271
36	V	32 Interest			100.00%	360	360
37	V	33 Real Estate Taxes			100.00%	152	152
38	V	35 Rent-Equipment & Vehicles			100.00%	472	472
39	Total		\$ 127,600			\$ 160,655	\$ * 33,055

\* 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	19 Professional Services	\$	Sunset Land, LLC		\$		15
16	V	26 Insurance-Property		Sunset Land, LLC		4,230	4,230	16
17	V	30 Depreciation		Sunset Land, LLC		33,528	33,528	17
18	V	31 Amortization		Sunset Land, LLC		2,155	2,155	18
19	V	32 Interest		Sunset Land, LLC		27,023	27,023	19
20	V	33 Real Estate Taxes		Sunset Land, LLC		10,266	10,266	20
21	V	34 Rent-Income and Grounds	83,012	Sunset Land, LLC			(83,012)	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 83,012			\$ 77,202	\$ * (5,810)	39

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

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	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 &amp; ID Number

Sunset Rehabilitation &amp; HC

# 0052993

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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 &amp; ID Number

Sunset Rehabilitation &amp; HC

# 0052993

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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 Rehabilitation & HC

# 0052993

Report Period Beginning:

1/1/14

Ending:

12/31/14

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			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				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 &amp; ID Number

Sunset Rehabilitation &amp; HC

#

0052993

Report Period Beginning:

1/1/14

Ending:

12/31/14

## VII. RELATED PARTIES (continued)

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

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

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

# 0052993

Report Period Beginning:

1/1/14

Ending: 12/31/14

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	1,572,338	77	\$ 231,473	\$ 220,289	29,574	\$ 4,354	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	29,574	104	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	29,574	22	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	29,574	294	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	29,574	1,652	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	29,574	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	29,574	35	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	29,574	1	8
9	10A	TherBXy	Resident Days	1,572,338	77	0	0	29,574	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	29,574	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	29,574	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	29,574	3,755	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	29,574	209	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	29,574	49,010	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	29,574	2,228	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	29,574	25	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	29,574	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	29,574	3,963	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	29,574	699	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	29,574	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	29,574	4,003	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	29,574	2,545	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	29,574	197	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	29,574	1,007	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 74,118	25

Facility Name & ID Number Sunset Rehabilitation & HC

# 0052993

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 Management, 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	1,572,338	77	\$ 299,961	\$ 294,997	29,574	\$ 5,642	1
2	2	Food	Resident Days	1,572,338	77	675		29,574	13	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	29,574	39	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		29,574	82	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	29,574	2,106	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			29,574		6
7	9	Medical Director	Resident Days	1,572,338	77			29,574		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		29,574	27	8
9	10A	TherBXy	Resident Days	1,572,338	77			29,574		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			29,574		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	29,574	57,334	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		29,574	8,482	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		29,574	68	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	29,574	61,920	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	1,135,672		29,574	21,361	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		29,574	20	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		29,574	23	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		29,574	2,106	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		29,574	177	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			29,574		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		29,574	271	21
22	32	Interest	Resident Days	1,572,338	77	19,133		29,574	360	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		29,574	152	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		29,574	472	24
25	TOTALS					\$ 10,069,824	\$ 8,113,127		\$ 160,655	25

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

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Bank of America		X	Mortgage	Varies	08/31/02	\$ 4,050,000	\$ 2,800,795			\$ 102,799	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 4,050,000	\$ 2,800,795			\$ 102,799	9					
	<b>B. Non-Facility Related*</b>																
10												10					
11											(1,904)	11					
12											2,545	12					
13											360	13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 1,001	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 4,050,000	\$ 2,800,795			\$ 103,800	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.			\$ <b>39,900</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.)	2013		\$ <b>39,872</b>	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(28)</b>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>41,064</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>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		<b>Home Office Allocation</b>	<b>349</b>	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>41,385</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>34,773</u>	8		
	2010	<u>35,928</u>	9		
	2011	<u>38,164</u>	10		
	2012	<u>38,742</u>	11		
	2013	<u>39,872</u>	12		
<b>Accrual based on prior year tax bill.</b>					
				<b>FOR BHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2013 \$ 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        X   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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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: 189,644 2. Number of Years Over Which it is Being Amortized: 20  
 3. Current Period Amortization: 2,155 4. Dates Incurred: 2013-2014

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

Facility Name & ID Number Sunset Rehabilitation & HC# 0052993

Report Period Beginning:

1/1/14

Ending:

12/31/14**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	\$ 964,587	4
5			2001	413,768		20	20,688	20,688	279,288	5
6	2		2003	148,271		20	7,414	7,414	85,261	6
7	8		2005	355,587		39	9,118	9,118	86,621	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			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	13,026	13
14										14
15	Field Audit		1990	1,102		15			1,102	15
16	Drapes		1995	8,206		20	410	410	7,927	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

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Elevator	2014	\$ 238,169	\$	25	\$ 6,351	\$ 6,351	\$ 6,351	37
38	Compressor	2014	2,931		7	174	174	174	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Land Improvements Booked			179			(179)		63
64	Building Booked			73,686			(73,686)		64
65	Building Improvement Booked			37,701			(37,701)		65
66									66
67	2014-Home Office Allocation-Building Improvements		13,805			331	331		67
68	2014-Home Office Allocation-Land Improvements		1,289			71	71		68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,627,090	\$ 111,566		\$ 127,019	\$ 15,453	\$ 1,542,815	70

\*\*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	\$ 30,119	\$ 2,776	\$	\$ (2,776)	5-10 yrs.	\$	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets	308,056						73
74	Home Office Allocation			3,872	3,872			74
75	TOTALS	\$ 338,175	\$ 2,776	\$ 3,872	\$ 1,096		\$	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		Grand		\$ 47,863	\$	\$	\$		\$ 47,863	76
77		Chevy		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)	\$ 4,125,271	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,342	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 130,891	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,549	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,607,821	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 & HC

# 0052993

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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: \$ 26,782 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 E150	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 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.

0  
0  
Period Beginning 1/1/2014  
Period End 12/31/2014

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 18,951
Dishwasher	1,088
Laundry Equipment	-
Copier	5,264
Home Office Allocation	1,479
	<u>26,782</u>

Facility Name & ID Number Sunset Rehabilitation & HC # 0052993 Report Period Beginning: 1/1/14 Ending: 12/31/14  
**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>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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	9,071	\$	136,059	\$	9,071	\$	136,059	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,694		25,416		1,694		25,416	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10A(3)	hrs		10,186		152,784		10,186		152,784	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					51,601			51,601	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>			\$	20,951	\$	314,259	\$	51,601	20,951	\$	365,860	14

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

Facility Name & ID Number Sunset Rehabilitation & HC# 0052993Report Period Beginning: 1/1/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 94,518	\$ 94,518	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>218,354</u> )	828,615	828,615	3
4	Supply Inventory (priced at _____)	15,021	15,021	4
5	Short-Term Investments			5
6	Prepaid Insurance	40,869	41,451	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		28,615	8
9	Other(specify): <u>Prepaid Expenses</u>	1,795,466	1,795,466	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,774,489	\$ 2,803,686	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		3,246,431	14
15	Leasehold Improvements, at Historical Cost	2,931	380,659	15
16	Equipment, at Historical Cost	65,006	403,181	16
17	Accumulated Depreciation (book methods)	(65,180)	(1,607,821)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		187,489	20
21	Restricted Funds		249,481	21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,757	\$ 2,954,420	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,777,246	\$ 5,758,106	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,056,243	\$ 1,056,243	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,015	116,015	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,550	60,550	31
32	Accrued Real Estate Taxes(Sch.IX-B)		41,064	32
33	Accrued Interest Payable		8,986	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	131,551	131,551	36
37	<u>Accrued Management Fees</u>	129,348	129,348	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,493,707	\$ 1,543,757	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,800,795	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Intercompany Loans</u>	(510,691)	(1,156,457)	43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ (510,691)	\$ 1,644,338	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 983,016	\$ 3,188,095	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,794,230	\$ 2,570,011	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,777,246	\$ 5,758,106	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,630,230</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>4,630,231</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>99,879</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>99,879</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfer of Net Assets to Land Company</b>	<b>(2,935,880)</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>(2,935,880)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,794,230</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		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 3,944,066	1	
2	Discounts and Allowances for all Levels	(489,193)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,454,873</b>	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	588,040	6	
7	Oxygen	2,871	7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 590,911</b>	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals	6,033	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	98,063	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray	6,522	20	
21	Other Medical Services	6,808	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 117,426</b>	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	1,904	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,904</b>	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	Miscellaneous Revenue	40,741	28	
28a	Transportation Revenue	4,531	28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 45,272</b>	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,210,386</b>	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	882,673	31	
32	Health Care	1,830,164	32	
33	General Administration	517,830	33	
<b>B. Capital Expense</b>				
34	Ownership	302,836	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	334,892	35	
36	Provider Participation Fee	242,112	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,110,507</b>	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>99,879</b>	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 99,879</b>	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,381,453	44
45	Private Pay - Net Inpatient Revenue	724,276	45
46	Medicare - Net Inpatient Revenue	358,943	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(9,799)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 3,454,873</b>	49

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

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

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

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

Facility Name & ID Number **Sunset Rehabilitation & HC**

# **0052993**

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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	2,152	2,272	\$ 73,856	\$ 32.51	1
2	Assistant Director of Nursing	2,052	2,116	50,413	23.82	2
3	Registered Nurses	6,085	6,213	137,696	22.16	3
4	Licensed Practical Nurses	16,941	17,890	371,068	20.74	4
5	CNAs & Orderlies	54,776	56,086	607,607	10.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,890	1,968	23,457	11.92	9
10	Activity Assistants	1,053	1,064	10,726	10.08	10
11	Social Service Workers	2,080	2,080	24,658	11.85	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,489	12.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,405	14,065	137,185	9.75	15
16	Dishwashers					16
17	Maintenance Workers	2,132	2,212	32,959	14.90	17
18	Housekeepers	20,825	21,761	216,332	9.94	18
19	Laundry	14,128	14,882	24,028	1.61	19
20	Administrator	2,080	2,080	57,334	27.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	26,323	12.66	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>	7,713	7,815	139,089	17.80	33
34	TOTAL (lines 1 - 33)	151,472	156,664	\$ 1,958,220 *	\$ 12.50	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	8	\$ 399	L1, C3	35
36	Medical Director	Monthly	16,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,246	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)	8	\$ 23,145		49

**C. CONTRACT NURSES**

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

Sunset Rehabilitation & HC

0052993

Period Beginning

1/1/2014

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12/31/2014

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	2,080	2,080	44,202	21.25
Transportation	1,473	1,575	16,799	10.67
Restorative Nurse	2,080	2,080	48,088	23.12
Marketing	2,080	2,080	30,000	14.42
<b>TOTAL</b>	<u>7,713</u>	<u>7,815</u>	<u>139,089</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	
Michelle Hansmeyer	Administrator	0	\$ 57,334	Workers' Compensation Insurance	\$ 71,195	IDPH License Fee	\$ 6,325	
				Unemployment Compensation Insurance	63,618	Advertising: Employee Recruitment		
				FICA Taxes	143,898	Health Care Worker Background Check		
				Employee Health Insurance	(4,358)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	169 1,699	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	0	
				Employee Relations	1,534	Miscellaneous Dues & Subscriptions	3,112	
				Employee Retirement	1,686	Home Office Allocation	277	
				Home Office Allocation	23,589			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 57,334			Less: Public Relations Expense	(597)	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 127,600					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 127,600				
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
Comcast	Computer Services		1,317				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,309					
Illinois Secretary of State	Filing Fees		211				In-State Travel	
Honkamp Krueger & Co.	Accounting Fees		1,909	N/A				
Curaspan	Data Services		2,700				Seminar Expense	
							Home Office Allocation	38
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 8,445			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 38

\* Attach copy of IMRF notifications

\*\*See instructions.

**Sunset Rehabilitation & HC**

0052993

Period Beginning

1/1/2014

Period End

12/31/2014

**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)		8,445

**Home Office Allocation**

Lexis Nexis	Legal	10
GoffWilson	Legal	689
Illinois Secretary of State	Legal	62
Bank of America	Legal	208
Healthcare Resources International	Legal	125
Miscellaneous	Legal	27
Addy, Bush	Legal	18
Hall, Rustom, and Fritz	Legal	21
Black, Hedin, Ballard	Legal	36
SmithAmundsen	Legal	37
CliftonLarson Allen	Accountants	1,466
Ginoli & Co.	Accountants	1,345
Miscellaneous	Computer Services	27
Odessian LLC	Computer Services	9
Optimizer	Computer Services	58
Allpayer Exchange	Computer Services	18
CCH	Computer Services	31
Prism Software	Computer Services	94
Macquarie Technology Services	Computer Services	82
Advanced Answers on Demand	Computer Services	4,344
Stratus Networks	Computer Services	572
Kemper Technology	Computer Services	1,694
AT&T	Computer Services	6
Ability Network	Computer Services	657
Barracuda	Computer Services	150
CIAN	Computer Services	178
Comcast	Computer Services	44

Emdeon	Computer Services	116
Charter Communications	Computer Services	7
Crawford County Title Co.	Other Prof Fees	8
Better Banks	Other Prof Fees	5
David Budde	Other Prof Fees	51
All Scripts	Other Prof Fees	34
Miscellaneous	Other Prof Fees	8
Total (agree to Schedule V, line 19, column 8)		<u>20,682</u>

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

Facility Name & ID Number Sunset Rehabilitation & HC# 0052993

Report Period Beginning:

1/1/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA 2516
- (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. \$ 14,418 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. \$ 242,112  
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. \$ 6,033
- (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. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adquate 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. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.