

Facility Name & ID Number Sunset Rehabilitation & HC

0052993 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	25	Skilled (SNF)	25	9,125	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		6,182	1,895	8,077	8
9	SNF/PED					9
10	ICF	26,515			26,515	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,515	6,182	1,895	34,592	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.41%

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 1,457

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Sunset Rehabilitation & HC # 0052993 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	166,515	25,021		191,536		191,536	7,106	198,642		1
2	Food Purchase		260,296		260,296		260,296	(61,086)	199,210		2
3	Housekeeping	227,214	28,693		255,907		255,907	124	256,031		3
4	Laundry	14,920	17,701		32,621		32,621		32,621		4
5	Heat and Other Utilities			114,728	114,728		114,728	414	115,142		5
6	Maintenance	33,947	8,293	30,294	72,534		72,534	4,751	77,285		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	442,596	340,004	145,022	927,622		927,622	(48,691)	878,931		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	1,440,424	104,469	8,532	1,553,425		1,553,425	(65)	1,553,360		10
10a	Therapy			256,862	256,862		256,862		256,862		10a
11	Activities	59,498	349	184	60,031		60,031	(2,256)	57,775		11
12	Social Services	26,068	89		26,157		26,157		26,157		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	1,525,990	104,907	275,578	1,906,475		1,906,475	(2,321)	1,904,154		16
	C. General Administration										
17	Administrative			326,100	326,100		326,100	(266,050)	60,050		17
18	Directors Fees										18
19	Professional Services			(1,692)	(1,692)		(1,692)	41,551	39,859		19
20	Dues, Fees, Subscriptions & Promotions			5,324	5,324		5,324	170	5,494		20
21	Clerical & General Office Expenses	27,927	7,740	17,292	52,959		52,959	84,369	137,328		21
22	Employee Benefits & Payroll Taxes			252,371	252,371		252,371	46,318	298,689		22
23	Inservice Training & Education							159	159		23
24	Travel and Seminar							77	77		24
25	Other Admin. Staff Transportation			21,244	21,244		21,244	6,517	27,761		25
26	Insurance-Prop.Liab.Malpractice			28,041	28,041		28,041	23,164	51,205		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	27,927	7,740	648,680	684,347		684,347	(63,725)	620,622		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,996,513	452,651	1,069,280	3,518,444		3,518,444	(114,737)	3,403,707		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 Rehabilitation & HC

#0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			1,630	1,630		1,630	179,953	181,583			30
31	Amortization of Pre-Op. & Org.							8,620	8,620			31
32	Interest							115,275	115,275			32
33	Real Estate Taxes							44,898	44,898			33
34	Rent-Facility & Grounds			330,090	330,090		330,090	(330,090)				34
35	Rent-Equipment & Vehicles			37,923	37,923		37,923	1,490	39,413			35
36	Other (specify):*											36
37	TOTAL Ownership			369,643	369,643		369,643	20,146	389,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,574		46,574		46,574		46,574			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			76	76		76		76			41
42	Provider Participation Fee			259,698	259,698		259,698		259,698			42
43	Other (specify):*	33,000	1,782	88,323	123,105		123,105	(123,105)				43
44	TOTAL Special Cost Centers	33,000	48,356	348,097	429,453		429,453	(123,105)	306,348			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,029,513	501,007	1,787,020	4,317,540		4,317,540	(217,696)	4,099,844			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	(9,966)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,420)	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	45,358	30		9
10	Interest and Other Investment Income	258	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(722)	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	(24,223)	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	(44,800)	43		24
25	Fund Raising, Advertising and Promotional	(3,410)	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	(96,267)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,192)		\$	30

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)	(75,504)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (75,504)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (217,696)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Sunset Rehabilitation & HC

ID# 0052993

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,134)	43	1
2	X-Rays-Part A	(2,821)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(369)	21	3
4	Offset Miscellaneous Nursing Supplies-General	(276)	10	4
5	Offset Transportation Revenue	(2,256)	11	5
6	Offset Meals on Wheels Revenue	(51,249)	2	6
7	Disallowed Marketing Salaries	(33,000)	43	7
8	Disallowed Special Events	(1,162)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(96,267)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunset Rehabilitation & HC# 0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	7,106	0	0	0	0	0	0	0	0	0	7,106	1
2	Food Purchase	(61,215)	129	0	0	0	0	0	0	0	0	0	(61,086)	2
3	Housekeeping	0	124	0	0	0	0	0	0	0	0	0	124	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	414	0	0	0	0	0	0	0	0	0	414	5
6	Maintenance	0	3,879	0	0	872	0	0	0	0	0	0	4,751	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(61,215)	11,652	0	0	872	0	0	0	0	0	0	(48,691)	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	(276)	211	0	0	0	0	0	0	0	0	0	(65)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,256)	0	0	0	0	0	0	0	0	0	0	(2,256)	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	(2,532)	211	0	0	0	0	0	0	0	0	0	(2,321)	16
	C. General Administration													
17	Administrative	0	(266,050)	0	0	0	0	0	0	0	0	0	(266,050)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	18,095	0	16,616	6,840	0	0	0	0	0	0	41,551	19
20	Fees, Subscriptions & Promotions	0	0	757	0	0	0	0	0	0	0	0	757	20
21	Clerical & General Office Expenses	(369)	0	82,835	0	1,903	0	0	0	0	0	0	84,369	21
22	Employee Benefits & Payroll Taxes	0	0	46,318	0	0	0	0	0	0	0	0	46,318	22
23	Inservice Training & Education	0	0	159	0	0	0	0	0	0	0	0	159	23
24	Travel and Seminar	0	0	77	0	0	0	0	0	0	0	0	77	24
25	Other Admin. Staff Transportation	0	0	6,517	0	0	0	0	0	0	0	0	6,517	25
26	Insurance-Prop.Liab.Malpractice	0	0	918	0	22,246	0	0	0	0	0	0	23,164	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(369)	(247,955)	137,581	16,616	30,989	0	0	0	0	0	0	(63,138)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(64,116)	(236,092)	137,581	16,616	31,861	0	0	0	0	0	0	(114,150)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunset Rehabilitation & HC# 0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	45,358	0	18,330	0	116,265	0	0	0	0	0	0	179,953	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	8,620	0	0	0	0	0	0	8,620	31
32	Interest	258	0	538	12,552	101,927	0	0	0	0	0	0	115,275	32
33	Real Estate Taxes	0	0	422	0	44,476	0	0	0	0	0	0	44,898	33
34	Rent-Facility & Grounds	0	0	0	0	(330,090)	0	0	0	0	0	0	(330,090)	34
35	Rent-Equipment & Vehicles	0	0	1,490	0	0	0	0	0	0	0	0	1,490	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	45,616	0	20,780	12,552	(58,802)	0	0	0	0	0	0	20,146	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):*	(123,692)	0	0	0	0	0	0	0	0	0	0	(123,692)	43
44	TOTAL Special Cost Centers	(123,692)	0	0	0	0	0	0	0	0	0	0	(123,692)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(142,192)	(236,092)	158,361	29,168	(26,941)	0	0	0	0	0	0	(217,696)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 7,106	\$ 7,106	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	129	129	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	124	124	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	414	414	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	3,879	3,879	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	211	211	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	326,100	Petersen Health Care Management, Inc.	100.00%	60,050	(266,050)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	18,095	18,095	12
13	V							13
14	Total		\$ 326,100			\$ 90,008	\$ * (236,092)	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 Management, Inc.	100.00%	\$ 757	\$	757	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	82,835		82,835	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	46,318		46,318	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	159		159	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	77		77	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	6,517		6,517	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	918		918	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	18,330		18,330	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	538		538	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	422		422	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,490		1,490	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		\$			\$ 158,361	\$ *	158,361	39

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

Facility Name & ID Number

Sunset Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending: 12/31/2016

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	\$	Petersen Health Junction, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Junction, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Junction, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Junction, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Junction, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Junction, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Junction, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Junction, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Junction, LLC	100.00%	16,616	16,616	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Junction, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Junction, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Junction, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Junction, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Junction, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Junction, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Junction, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Junction, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Junction, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Junction, LLC	100.00%	12,552	12,552	35	
36	V	33 Real Estate Taxes		Petersen Health Junction, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Junction, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Junction, LLC	100.00%	0		38	
39	Total		\$			\$ 29,168	\$ *	29,168	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	19 Professional Fees	\$	Sunset Land	100.00%	\$ 6,840	\$ 6,840
16	V	26 Property Insurance		Sunset Land	100.00%	4,889	4,889
17	V	26 Mortgage Insurance		Sunset Land	100.00%	17,357	17,357
18	V	30 Depreciation		Sunset Land	100.00%	116,265	116,265
19	V	31 Amortization		Sunset Land	100.00%	8,620	8,620
20	V	32 Interest	891	Sunset Land	100.00%	102,818	101,927
21	V	33 Real Estate Taxes		Sunset Land	100.00%	44,476	44,476
22	V	34 Rent-Facility & Grounds	330,090	Sunset Land	100.00%		(330,090)
23	V	6 Maintenance		Sunset Land	100.00%	872	872
24	V	21 Minor Equipment		Sunset Land	100.00%	1,903	1,903
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 330,981			\$ 304,040	\$ * (26,941)

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

Facility Name & ID Number

Sunset Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending: 12/31/2016

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 I	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 Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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 Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Sunset Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Sunset Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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 Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	N/A									3
4										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 Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization 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

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	1,521,544	75	\$ 312,540	\$ 357,910	34,592	\$ 7,106	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	34,592	129	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	34,592	124	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	34,592	414	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	34,592	3,879	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	34,592	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	34,592	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	34,592	211	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	34,592	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	34,592	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	34,592	60,050	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	34,592	18,095	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	34,592	757	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	34,592	82,835	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	34,592	46,318	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	34,592	159	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	34,592	77	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	34,592	6,517	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	34,592	918	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	34,592	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	34,592	18,330	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	34,592	538	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	34,592	422	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	34,592	1,490	24
25	TOTALS					\$ 13,182,740	\$ 11,510,481		\$ 248,369	25

Facility Name & ID Number Sunset Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Petersen Health Junction, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309)691-8113
 Fax Number (309)691-8622

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	57,459	2	\$	34,592	\$	1
2	2	Food	Resident Days	57,459	2		34,592		2
3	3	Housekeeping	Resident Days	57,459	2		34,592		3
4	4	Laundry	Resident Days	57,459	2		34,592		4
5	5	Utilities	Resident Days	57,459	2		34,592		5
6	6	Maintenance	Resident Days	57,459	2		34,592		6
7	7	Mgmt. Allocation of Benefits	Resident Days	57,459	2		34,592		7
8	10	Nursing and Medical Records	Resident Days	57,459	2		34,592		8
9	15	Mgmt. Allocation of Benefits	Resident Days	57,459	2		34,592		9
10	17	Administrative	Resident Days	57,459	2		34,592		10
11	19	Professional Services	Resident Days	57,459	2	28,005	34,592	16,616	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	57,459	2		34,592		12
13	21	Clerical and General Office	Resident Days	57,459	2		34,592		13
14	22	Employee Benefits & Payroll	Resident Days	57,459	2		34,592		14
15	23	Inservice Training & Education	Resident Days	57,459	2		34,592		15
16	24	Travel and Seminar	Resident Days	57,459	2		34,592		16
17	25	Other Admin. Staff Transport.	Resident Days	57,459	2		34,592		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	57,459	2		34,592		18
19	30	Depreciation	Resident Days	57,459	2		34,592		19
20	31	Amortization	Resident Days	57,459	2		34,592		20
21	32	Interest	Resident Days	57,459	2	21,156	34,592	12,552	21
22	33	Real Estate Taxes	Resident Days	57,459	2		34,592		22
23	34	Rent-Facility and Grounds	Resident Days	57,459	2		34,592		23
24	35	Rent-Equipment & Vehicles	Resident Days	57,459	2		34,592		24
25	TOTALS					\$ 49,161	\$	\$ 29,168	25

Facility Name & ID Number

Sunset Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	First Merit		X	Mortgage	Varies	10/1/14	\$ 2,814,400	\$ 2,630,547	9/30/39	Varies	\$ 102,818	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,814,400	\$ 2,630,547			\$ 102,818	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(633)	10						
11									Home Office Allocation-PHCM		538	11						
12									Home Office Allocation-PHJ		12,552	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 12,457	14						
15	TOTALS (line 9+line14)						\$ 2,814,400	\$ 2,630,547			\$ 115,275	15						

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunset Rehabilitation & HC COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0052993

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-08-27-438-017</u>	<u>Long-Term Care Facility</u>	\$ <u>42,291.66</u>	\$ <u>42,291.66</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>42,291.66</u></u>	\$ <u><u>42,291.66</u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.**

Facility Name & ID Number Sunset Rehabilitation & HC

0052993 Report Period Beginning:

1/1/2016 Ending:

12/31/2016

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: 8,620 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	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	\$ 1,118,921	4
5				2001	413,768		20	20,688	20,688	320,664	5
6	2			2003	148,271		20	7,414	7,414	100,089	6
7	8			2005	355,587		39	9,118	9,118	104,857	7
8											8
	Improvement Type**										
9	1990-1995 Fully Depreciated Assets										
10				1995	37,344					37,344	9
10				1995	8,206		20			8,206	10
11				1996	14,630		20	732	732	14,032	11
12				1996	1,105		20	55	55	1,050	12
13				1996	4,036		20	202	202	3,973	13
14				1996	531		20	27	27	479	14
15				1997	500		20	25	25	450	15
16				1997	5,250		20	263	263	4,997	16
17				1997	8,228		20	411	411	7,775	17
18				1997	2,759		20	138	138	2,588	18
19				1997	1,886		20	94	94	1,763	19
20				1997	1,688		20	84	84	1,540	20
21				1997	1,440		20	72	72	1,344	21
22				1997	1,207		20	60	60	1,125	22
23				1997	2,389		20	119	119	2,162	23
24				1997	4,077		20	204	204	3,774	24
25				1997	1,189		20	59	59	1,077	25
26				1998	36,145		20	1,807	1,807	31,623	26
27				1998	1,402		20	70	70	1,225	27
28				1998	3,639		20	182	182	3,185	28
29				1998	619		20	31	31	543	29
30				1999	\$ 353	\$	20	\$ 18	18	315	30
31				1999	1,000		20	50	50	875	31
32				2000	1,966		20	98	98	1,617	32
33				2000	1,072		20	54	54	891	33
34				2000	1,945		20	97	97	1,605	34
35				2000	1,072		20	54	54	891	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

Facility Name & ID Number Sunset Rehabilitation & HC# 0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016**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	Land Work	2000	2,510		20	126	\$ 126	\$ 2,079	37
38	Flooring	2000	1,168		20	58	58	957	38
39	Shades	2001	1,788		20	89	89	1,380	39
40	Painting	2001	2,228		20	111	111	1,721	40
41	Carpet	2001	4,841		20	242	242	3,751	41
42	Carpet	2001	8,000		20	400	400	6,200	42
43	Painting	2001	345		20	17	17	264	43
44	Fire System	2001	42,286		20	2,114	2,114	32,767	44
45	Carpet	2001	2,155		20	108	108	1,674	45
46	Kitchen Remodeling	2001	43,315		20	2,166	2,166	33,573	46
47	Expansion	2002	7,352		20	368	368	5,338	47
48	Wall	2002	6,000		20	300	300	4,350	48
49	New Addition	2004	3,021		20	151	151	1,889	49
50	Stairway, sunroom, new addition	2004	218,275		20	10,914	10,914	136,425	50
51	Engineering Fees	2005	2,047		20	102	102	1,173	51
52	IDPH Planning Fee	2005	2,976		20	149	149	1,713	52
53	Architect Fees	2005	1,904		20	98	98	1,123	53
54	Asphalt West Lot	2006	21,480		20	1,074	1,074	11,456	54
55	Air Conditioner	2007	3,000		10	300	300	827	55
56	Wheelchair Ramp	2007	930		15	62	62	589	56
57	Fencing	2008	3,634		39	94	94	799	57
58	Generator Repair	2009	3,214		7	224	224	3,214	58
59	Boiler and Mixing Valve Repair	2009	5,449		7	392	392	5,449	59
60	Boiler Repair	2009	2,582		7	190	190	2,582	60
61	Air Conditioner-Dining Room	2009	3,834		7	272	272	3,834	61
62	Roof Installation	2009	6,752		15	450	450	3,375	62
63	Sunroom	2009	10,779		35	308	308	2,310	63
64	Water Heater	2010	6,518		7	932	932	6,058	64
65	Air Conditoner Repair	2010	3,308		7	472	472	3,068	65
66	Boiler	2010	14,000		20	700	700	4,550	66
67	Boiler	2012	22,000		15	1,466	1,466	6,597	67
68	Carpeting-Lobby, A Wing, Medium Wing, Alzheimers Hall	2013	36,269		15	2,418	2,418	8,463	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,872,264	\$		\$ 146,260	\$ 146,260	\$ 2,080,528	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		\$ 3,872,264	\$		\$ 146,260	\$ 146,260	\$ 2,080,528	1
2	Furnace and Air Conditoner	2013	6,920		15	462	462	1,617	2
3	Boilers	2013	23,500		15	1,566	1,566	5,481	3
4	Roof Repair	2013	5,369		7	768	768	2,688	4
5	Elevator Replacement	2014	238,169		25	9,528	9,528	23,820	5
6	Compressor	2014	2,931		7	419	419	1,048	6
7	Furnace	2016	4,035		15	135	135	135	7
8	Water Heater	2016	10,397		7	743	743	743	8
9	Flooring in Office Area	2016	7,215		10	722	722	722	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	Land Improvements Booked			179			(179)		26
27	Building Booked			73,687			(73,687)		27
28	Building Improvement Booked			40,244			(40,244)		28
29									29
30	2016-Home Office Allocation-Building Improvements		15,272			366	366		30
31	2016-Home Office Allocation-Land Improvements		1,405			91	91		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,187,477	\$ 114,110		\$ 161,060	\$ 46,950	\$ 2,116,782	34

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

Facility Name & ID Number Sunset Rehabilitation & HC

0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	\$ 30,290	\$ 3,785	\$ 2,650	\$ (1,135)	5-10 yrs.	\$ 13,604	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	308,056					308,056	73
74	Home Office Allocation			17,873	17,873			74
75	TOTALS	\$ 338,346	\$ 3,785	\$ 20,523	\$ 16,738		\$ 321,660	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)	\$ 4,685,829	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,895	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,583	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 63,688	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,503,448	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			93
94	N/A		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: 1/1/2016

Ending: 12/31/2016

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 32,475 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			\$ <u>578.00</u>	\$ <u>6,938</u>	17
18	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$ <u>578.00</u>	\$ <u>6,938</u>	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 Rehabilitation & HC

0052993

Period Beginning 1/1/2016

Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 25,361
Dishwasher	704
Copier	4,920
Home Office Allocation	1,490
	<u>32,475</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,774	\$ 101,615	\$	6,774	\$ 101,615	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		901	13,517		901	13,517	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,449	141,730		9,449	141,730	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				46,574		46,574	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			\$	17,124	\$ 256,862	\$ 46,574	17,124	\$ 303,436	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

0052993

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(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	\$ (363,020)	\$ (363,020)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>25,199</u>)	1,947,027	1,947,027	3
4	Supply Inventory (priced at <u>Cost</u>)	15,021	15,021	4
5	Short-Term Investments			5
6	Prepaid Insurance	32,448	46,965	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	650,131	43,643	8
9	Other(specify): <u>Prepaid Expenses</u>	137,610	137,610	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,419,217	\$ 1,827,246	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		95,000	13
14	Buildings, at Historical Cost		3,247,898	14
15	Leasehold Improvements, at Historical Cost	20,544	939,579	15
16	Equipment, at Historical Cost	69,600	403,352	16
17	Accumulated Depreciation (book methods)	(67,393)	(2,503,448)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		170,249	20
21	Restricted Funds		383,296	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,751	\$ 2,735,926	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,441,968	\$ 4,563,172	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 497,017	\$ 499,791	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,532	121,532	30
31	Accrued Taxes Payable (excluding real estate taxes)	52,890	52,890	31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,560	32
33	Accrued Interest Payable		8,440	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	257,619	257,619	36
37	<u>Accrued Management Fees</u>	8,632	8,632	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 937,690	\$ 992,464	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,630,547	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	3,321	3,321	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,321	\$ 2,633,868	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 941,011	\$ 3,626,332	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,500,957	\$ 936,840	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,441,968	\$ 4,563,172	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 748,523	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(10,999)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 737,524	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	763,433	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)	\$ 763,433	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)	\$ 1,500,957	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Sunset Rehabilitation & HC**# **0052993**Report Period Beginning: **1/1/2016**Ending: **12/31/2016****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	\$ 4,675,204	1
2	Discounts and Allowances for all Levels	(249,130)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,426,074	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	476,210	6
7	Oxygen	820	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 477,030	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	61,215	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	91,033	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,591	20
21	Other Medical Services	15,352	21
22	Laundry	35	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 175,226	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(258)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (258)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,256	28
28a	<u>Miscellaneous & Meals on Wheels Revenue</u>	645	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,901	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,080,973	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	927,622	31
32	Health Care	1,906,475	32
33	General Administration	684,347	33
B. Capital Expense			
34	Ownership	369,643	34
C. Ancillary Expense			
35	Special Cost Centers	169,755	35
36	Provider Participation Fee	259,698	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,317,540	40
41	Income before Income Taxes (line 30 minus line 40)**	763,433	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 763,433	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,216,599	44
45	Private Pay - Net Inpatient Revenue	925,210	45
46	Medicare - Net Inpatient Revenue	242,790	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	41,475	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,426,074	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:

1/1/2016

Ending:

12/31/2016

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	\$ 56,168	\$ 27.00	1
2	Assistant Director of Nursing	1,040	1,040	22,534	21.67	2
3	Registered Nurses	8,031	8,238	182,527	22.16	3
4	Licensed Practical Nurses	19,010	19,394	387,929	20.00	4
5	CNAs & Orderlies	63,777	65,382	722,081	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,285	1,309	20,862	15.94	9
10	Activity Assistants	1,151	1,151	15,572	13.53	10
11	Social Service Workers	2,828	2,885	26,068	9.04	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,481	12.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,010	14,459	141,034	9.75	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	33,947	16.32	17
18	Housekeepers	20,304	21,465	227,214	10.59	18
19	Laundry	1,630	1,647	14,920	9.06	19
20	Administrator	2,080	2,080	60,050	28.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	27,927	13.43	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	3,122	3,278	69,185	21.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Transportation</u>	1,984	2,057	23,064	11.21	32
33	Other(specify) <u>Marketing</u>	2,080	2,080	33,000	15.87	33
34	TOTAL (lines 1 - 33)	150,652	154,785	\$ 2,089,563 *	\$ 13.50	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	\$		35
36	Medical Director	Monthly 10,000	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 7,541	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	6 375	L10A, C3	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)	6 \$ 17,916		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

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	\$ 60,050	Workers' Compensation Insurance	\$ 39,333	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	57,645	Advertising: Employee Recruitment		
				FICA Taxes	149,591	Health Care Worker Background Check		
				Employee Health Insurance	2,989	(Indicate # of checks performed 30)	758	
				Employee Meals		Patient Background Checks	374	
				Illinois Municipal Retirement Fund (IMRF)*	1,803	Miscellaneous Licenses & Permits	615	
				Employee Relations	1,010	Miscellaneous Dues & Subscriptions	1,587	
				Home Office Allocation	46,318	Home Office Allocation	757	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 60,050					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 326,100					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 326,100					
(Attach a copy of any management service agreement)								
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		\$ 1,258				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		3,212					
Honkamp Krueger & Co.	Accounting Fees		568	N/A				
Fulton Co Recorder	Legal Fees		70				In-State Travel	
Peoria Co. Circuit Clerk	Legal Fees		40					
Capital Finance Group	Refund of Refinance Fees		(6,840)				Seminar Expense	
							Home Office Allocation	77
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ (1,692)				TOTAL	\$ 77

* Attach copy of IMRF notifications

**See instructions.

Sunset Rehabilitation & HC

0052993

Period Beginning

1/1/2016

Period End

12/31/2016

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

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		(1,692)

Home Office Allocation

Lucie, Scalf, and Bougher	Legal	81
Miscellaneous	Legal	29
Miller Hall and Triggs	Legal	140
Healthcare Resources International	Legal	697
Hunziker Law	Legal	167
Lexis Nexis	Legal	14
Illinois Secretary of State	Legal	148
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	725
Ginoli & Co.	Accountants	12,903
Capital Finance Group	Accountants	6,590
Miscellaneous	Computer Services	92
Change Healthcare	Computer Services	14
PTC Select	Computer Services	8
Advanced Answers on Demand	Computer Services	6,370
Stratus Networks	Computer Services	648
Kemper Technology	Computer Services	427
AT&T	Computer Services	9
Ability Network	Computer Services	2,716
CIAN	Computer Services	324
Comcast	Computer Services	53
CCH	Computer Services	21
Charter Communications	Computer Services	63
Allscripts	Computer Services	947
ATS	Computer Services	427
Allpayer Exchange	Computer Services	22
Optimizer	Other Prof Fees	65
Ankura	Other Prof Fees	494
David Budde	Other Prof Fees	56
Bruner, Cooper, Zuck	Other Prof Fees	144
Marotta, Gund, Budd, Dzerda	Other Prof Fees	6,823
Professional Software and Services	Other Prof Fees	36
Hughes Valuation Services	Other Prof Fees	45
Alan Litwiller	Other Prof Fees	3

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

39,859

Facility Name & ID Number Sunset Rehabilitation & HC# 0052993

Report Period Beginning:

1/1/2016

Ending:

12/31/2016**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 \$1000
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,604 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 259,698
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. \$ 9,966
- (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. \$ 2,256
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli 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

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-217,696	equal to	-217,696	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	115,275	equal to	115,275	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	44,898	equal to	44,898	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	8,620	equal to	8,620	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	181,583	equal to	181,583	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	39,413	equal to	39,413	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	256,862	equal to	256,862	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	46,574	equal to	46,574	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	927,622	equal to	927,622	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,906,475	equal to	1,906,475	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	684,347	equal to	684,347	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	369,643	equal to	369,643	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	169,755	equal to	169,755	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	259,698	equal to	259,698	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,440,424	equal to	1,440,424	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	59,498	equal to	59,498	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	26,068	equal to	26,068	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	166,515	equal to	166,515	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	33,947	equal to	33,947	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	227,214	equal to	227,214	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	14,920	equal to	14,920	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	60,050	equal to	60,050	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	27,927	equal to	27,927	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,089,563	equal to	2,029,513	60,050	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	0	#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	10,000	< or = to	10,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	7,916	< or = to	8,532	-616	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	184	-184	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	60,050	equal to	60,050	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	326,100	equal to	326,100	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	-1,692	equal to	-1,692	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	298,689	equal to	298,689	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,494	equal to	5,494	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	77	equal to	77	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	259,698	equal to	259,698	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,457	equal to	1,895	-438	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-75,504	equal to	-75,504	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	2,630,547	equal to	2,630,547	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	43,560	equal to	43,560	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	95,000	equal to	95,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,187,477	equal to	4,187,477	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	403,352	equal to	403,352	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,503,448	equal to	2,503,448	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,500,957	equal to	1,500,957	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	763,433	equal to	763,433	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,441,968	equal to	2,441,968	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	166,515	25,021	0	191,536	0	191,536	7,106	198,642
2. Food Purchase	0	260,296	0	260,296	0	260,296	-61,086	199,210
3. Housekeeping	227,214	28,693	0	255,907	0	255,907	124	256,031
4. Laundry	14,920	17,701	0	32,621	0	32,621	0	32,621
5. Heat and Other Utilities	0	0	114,728	114,728	0	114,728	414	115,142
6. Maintenance	33,947	8,293	30,294	72,534	0	72,534	4,751	77,285
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	442,596	340,004	145,022	927,622	0	927,622	-48,691	878,931
9. Medical Director	0	0	10,000	10,000	0	10,000	0	10,000
10. Nursing & Medical Records	1,440,424	104,469	8,532	1,553,425	0	1,553,425	-65	#####
10a. Therapy	0	0	256,862	256,862	0	256,862	0	256,862
11. Activities	59,498	349	184	60,031	0	60,031	-2,256	57,775
12. Social Services	26,068	89	0	26,157	0	26,157	0	26,157
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,525,990	104,907	275,578	1,906,475	0	1,906,475	-2,321	#####
17. Administrative	0	0	326,100	326,100	0	326,100	-266,050	60,050
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	-1,692	-1,692	0	-1,692	41,551	39,859
20. Fees, Subscriptions & Promotion	0	0	5,324	5,324	0	5,324	170	5,494
21. Clerical & General Office	27,927	7,740	17,292	52,959	0	52,959	84,369	137,328
22. Employee Benefits & Payroll	0	0	252,371	252,371	0	252,371	46,318	298,689
23. Inservice Training & Education	0	0	0	0	0	0	159	159
24. Travel and Seminar	0	0	0	0	0	0	77	77
25. Other Admin. Staff Trans	0	0	21,244	21,244	0	21,244	6,517	27,761
26. Insurance-Prop.Liab.Malpractice	0	0	28,041	28,041	0	28,041	23,164	51,205
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	27,927	7,740	648,680	684,347	0	684,347	-63,725	620,622
29. Total General Administrative	1,996,513	452,651	1,069,280	3,518,444	0	3,518,444	-114,737	#####
30. Depreciation	0	0	1,630	1,630	0	1,630	179,953	181,583
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	8,620	8,620
32. Interest	0	0	0	0	0	0	115,275	115,275
33. Real Estate	0	0	0	0	0	0	44,898	44,898
34. Rent - Facility & Grounds	0	0	330,090	330,090	0	330,090	-330,090	0
35. Rent - Equipment & Vehicles	0	0	37,923	37,923	0	37,923	1,490	39,413
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	369,643	369,643	0	369,643	20,146	389,789
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	46,574	0	46,574	0	46,574	0	46,574
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	76	76	0	76	0	76
42	0	0	259,698	259,698	0	259,698	0	259,698
43. Other (specify):*	33,000	1,782	88,323	123,105	0	123,105	-123,105	0
44. Total Special Cost Ce	33,000	48,356	348,097	429,453	0	429,453	-123,105	306,348
45. Grand Total	2,029,513	501,007	1,787,020	4,317,540	0	4,317,540	-217,696	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-363,020	-363,020
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,947,027	1,947,027
4. Supply Inventory	15,021	15,021
5. Short-Term Investments	0	0
6. Prepaid Insurance	32,448	46,965
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	650,131	43,643
9. Other (specify):	137,610	137,610
10. Total current assets	2,419,217	1,827,246
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	95,000
14. Buildings, at Historical Cost	0	3,247,898
15. Leasehold Improvements, Historical Cost	20,544	939,579
16. Equipment, at Historical Cost	69,600	403,352
17. Accumulated Depreciation (book methods)	-67,393	-2,503,448
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	170,249
21. Restricted Funds	0	383,296
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	22,751	2,735,926
25. Total Assets	2,441,968	4,563,172
CURRENT LIABILITIES		
26. Accounts Payable	497,017	499,791
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	121,532	121,532
31. Accrued Taxes Payable	52,890	52,890
32. Accrued Real Estate Taxes	0	43,560
33. Accrued Interest Payable	0	8,440
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	257,619	257,619
37. Other Current Liabilities (specify):	8,632	8,632
38. Total Current Liabilities	937,690	992,464
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	2,630,547
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	3,321	3,321
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	3,321	2,633,868
46. Total Liabilities	941,011	3,626,332
47. Total Equity	1,500,957	936,840
48. Total Liabilities and Equity	2,441,968	4,563,172

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	4,675,204
2. Discounts and Allowances for all Levels	-249,130
Subtotal - Inpatient Care	4,426,074
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	476,210
7. Oxygen	820
Subtotal - Ancillary Revenue	477,030
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	61,215
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	91,033
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	7,591
21. Other Medical Services	15,352
22. Laundry	35
Subtotal - Other Operating Revenue	175,226
24. Contributions	0
25. Interest and Other Investments Income	-258
Subtotal - Non-Operating Revenue	-258
27. Other Revenue (specify):	2,256
28. Other Revenue (specify):	645
Subtotal - Other Revenue	2,901
30. Total Revenue	5,080,973
31. General Services	897,441
32. Health Care	1,866,346
33. General Administration	677,432
34. Ownership	364,048
35. Special Cost Centers	266,709
35. Provider Participation Fee	254,849
37. Other	0
40. Total Expenses	4,326,825
41. Income Before Income Taxes	754,148
42. Income Taxes	0
43. Net Income or Loss for the Year	754,148