

Facility Name & ID Number Sunset Manor Nursing Home

0052993 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		5,315	1,444	6,759	8
9	SNF/PED					9
10	ICF	27,754			27,754	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,754	5,315	1,444	34,513	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.22%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 1,271

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Sunset Manor Nursing Home # 0052993 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	168,257	24,423	1,534	194,214		194,214	7,748	201,962		1
2	Food Purchase		239,492		239,492		239,492	(46,225)	193,267		2
3	Housekeeping	241,591	33,458		275,049		275,049	117	275,166		3
4	Laundry	16,601	17,057		33,658		33,658		33,658		4
5	Heat and Other Utilities			101,403	101,403		101,403	407	101,810		5
6	Maintenance	34,966	5,392	18,474	58,832		58,832	8,415	67,247		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	461,415	319,822	121,411	902,648		902,648	(29,538)	873,110		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,508,030	99,304	14,294	1,621,628		1,621,628	(246)	1,621,382		10
10a	Therapy		87	254,943	255,030		255,030		255,030		10a
11	Activities	61,580	297	611	62,488		62,488	(3,242)	59,246		11
12	Social Services	27,069			27,069		27,069		27,069		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	1,596,679	99,688	287,848	1,984,215		1,984,215	(3,488)	1,980,727		16
	C. General Administration										
17	Administrative			328,500	328,500		328,500	(266,500)	62,000		17
18	Directors Fees										18
19	Professional Services			6,363	6,363		6,363	65,015	71,378		19
20	Dues, Fees, Subscriptions & Promotions			8,248	8,248		8,248	(406)	7,842		20
21	Clerical & General Office Expenses	31,176	5,174	25,991	62,341		62,341	88,805	151,146		21
22	Employee Benefits & Payroll Taxes			228,956	228,956		228,956	37,508	266,464		22
23	Inservice Training & Education			500	500		500	231	731		23
24	Travel and Seminar							115	115		24
25	Other Admin. Staff Transportation			7,071	7,071		7,071	5,553	12,624		25
26	Insurance-Prop.Liab.Malpractice			28,128	28,128		28,128	24,078	52,206		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	31,176	5,174	633,757	670,107		670,107	(45,601)	624,506		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,089,270	424,684	1,043,016	3,556,970		3,556,970	(78,627)	3,478,343		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 Manor Nursing Home

#0052993

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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			2,035	2,035		2,035	188,752	190,787			30
31	Amortization of Pre-Op. & Org.							8,799	8,799			31
32	Interest							155,740	155,740			32
33	Real Estate Taxes							43,254	43,254			33
34	Rent-Facility & Grounds			327,969	327,969		327,969	(327,969)				34
35	Rent-Equipment & Vehicles			30,912	30,912		30,912	2,354	33,266			35
36	Other (specify):*											36
37	TOTAL Ownership			360,916	360,916		360,916	70,930	431,846			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,725		34,725		34,725		34,725			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			262,910	262,910		262,910		262,910			42
43	Other (specify):*	33,998	1,575	97,741	133,314		133,314	(133,314)				43
44	TOTAL Special Cost Centers	33,998	36,300	360,651	430,949		430,949	(133,314)	297,635			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,123,268	460,984	1,764,583	4,348,835		4,348,835	(141,011)	4,207,824			45

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

Sunset Manor Nursing Home

ID# 0052993

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,327)	43	1
2	X-Rays-Part A	(1,022)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(155)	21	3
4	Offset Miscellaneous Nursing Supplies-General	(354)	10	4
5	Offset Transportation Revenue	(3,242)	11	5
6	Offset Meals on Wheels Revenue	(38,232)	2	6
7	Disallowed Marketing Salaries	(33,998)	43	7
8	Disallowed Special Events	(576)	43	8
9	Disallowed Chamber of Commerce Dues	(587)	20	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	(79,493)		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	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%	\$ 7,748	\$ 7,748	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	33	33	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	117	117	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	407	407	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	3,661	3,661	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%	108	108	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	328,500	Petersen Health Care Management, Inc.	100.00%	62,000	(266,500)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	24,264	24,264	12
13	V							13
14	Total		\$ 328,500			\$ 98,338	\$ * (230,162)	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 & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 181	\$	181	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	83,389		83,389	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	37,508		37,508	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	231		231	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	115		115	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	5,553		5,553	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,471		1,471	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	19,858		19,858	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	179		179	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	646		646	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	445		445	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,354		2,354	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		\$			\$ 151,930	\$ *	151,930	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	\$	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%	35,976	35,976	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%	56,718	56,718	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		\$			\$ 92,694	\$ *	92,694	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	6 Maintenance	\$	Sunset Land	100.00%	4,754	\$ 4,754
16	V	19 Professional Fees		Sunset Land	100.00%	4,775	4,775
17	V	21 Equipment	\$	Sunset Land	100.00%	5,571	5,571
18	V	26 Property Insurance		Sunset Land	100.00%	5,826	5,826
19	V	26 Mortgage Insurance		Sunset Land	100.00%	16,781	16,781
20	V	30 Depreciation		Sunset Land	100.00%	118,719	118,719
21	V	31 Amortization		Sunset Land	100.00%	8,620	8,620
22	V	32 Interest	1,037	Sunset Land	100.00%	99,407	98,370
23	V	33 Real Estate Taxes		Sunset Land	100.00%	42,809	42,809
24	V	34 Rent-Facility & Grounds	327,969	Sunset Land	100.00%		(327,969)
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		\$ 329,006			\$ 307,262	\$ * (21,744)

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

Facility Name & ID Number

Sunset Manor Nursing Home

0052993

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

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 System	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	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 Busine	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

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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

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 Manor Nursing Home

0052993

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Sunset Manor Nursing Home

0052993

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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	1,451,714	75	\$ 325,901	\$ 376,129	34,513	\$ 7,748	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	34,513	33	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	34,513	117	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	34,513	407	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	34,513	3,661	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	34,513	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	34,513	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	34,513	108	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	34,513	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	34,513	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	34,513	62,000	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	34,513	24,264	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	34,513	181	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	34,513	83,389	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	34,513	37,508	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	34,513	231	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	34,513	115	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	34,513	5,553	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	34,513	1,471	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	835,302	0	34,513	19,858	20
21	30	Depreciation	Resident Days	1,451,714	75	7,526	0	34,513	179	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	34,513	646	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	34,513	445	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	34,513	2,354	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 250,268	25

Facility Name & ID Number Sunset Manor Nursing Home

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Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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	58,757	2	\$	\$	34,513	\$	1
2	2	Food	Resident Days	58,757	2			34,513		2
3	3	Housekeeping	Resident Days	58,757	2			34,513		3
4	4	Laundry	Resident Days	58,757	2			34,513		4
5	5	Utilities	Resident Days	58,757	2			34,513		5
6	6	Maintenance	Resident Days	58,757	2			34,513		6
7	7	Mgmt. Allocation of Benefits	Resident Days	58,757	2			34,513		7
8	10	Nursing and Medical Records	Resident Days	58,757	2			34,513		8
9	15	Mgmt. Allocation of Benefits	Resident Days	58,757	2			34,513		9
10	17	Administrative	Resident Days	58,757	2			34,513		10
11	19	Professional Services	Resident Days	58,757	2	61,247		34,513	35,976	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	58,757	2			34,513		12
13	21	Clerical and General Office	Resident Days	58,757	2			34,513		13
14	22	Employee Benefits & Payroll	Resident Days	58,757	2			34,513		14
15	23	Inservice Training & Education	Resident Days	58,757	2			34,513		15
16	24	Travel and Seminar	Resident Days	58,757	2			34,513		16
17	25	Other Admin. Staff Transport.	Resident Days	58,757	2			34,513		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	58,757	2			34,513		18
19	30	Depreciation	Resident Days	58,757	2			34,513		19
20	31	Amortization	Resident Days	58,757	2			34,513		20
21	32	Interest	Resident Days	58,757	2	96,560		34,513	56,718	21
22	33	Real Estate Taxes	Resident Days	58,757	2			34,513		22
23	34	Rent-Facility and Grounds	Resident Days	58,757	2			34,513		23
24	35	Rent-Equipment & Vehicles	Resident Days	58,757	2			34,513		24
25	TOTALS					\$ 157,807	\$		\$ 92,694	25

Facility Name & ID Number

Sunset Manor Nursing Home

0052993

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	CFG Capital Group		X	Mortgage	Varies	10/1/14	\$ 2,814,400	\$ 2,540,387	9/30/39	Varies	\$ 99,407	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,814,400	\$ 2,540,387			\$ 99,407	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(1,031)	10						
11									Home Office Allocation-PHCM		646	11						
12									Home Office Allocation-PHJ		56,718	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 56,333	14						
15	TOTALS (line 9+line14)						\$ 2,814,400	\$ 2,540,387			\$ 155,740	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 16,781 Line # 26

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

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

Facility Name & ID Number Sunset Manor Nursing Home

0052993 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

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: 8,799 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	\$	\$ 1,196,088	4
5				2001	413,768		20	20,688	20,688	341,352	5
6	2			2003	148,271		20	7,414	7,414	107,503	6
7	8			2005	355,587		39	9,118	9,118	113,975	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	598	598	14,630	11
12				1996	1,105		20	55	55	1,105	12
13				1996	4,036		20	63	63	4,036	13
14				1996	531		20	27	27	506	14
15				1997	500		20	25	25	475	15
16				1997	5,250		20	253	253	5,250	16
17				1997	8,228		20	411	411	8,186	17
18				1997	2,759		20	138	138	2,726	18
19				1997	1,886		20	94	94	1,857	19
20				1997	1,688		20	84	84	1,624	20
21				1997	1,440		20	72	72	1,416	21
22				1997	1,207		20	60	60	1,185	22
23				1997	2,389		20	119	119	2,281	23
24				1997	4,077		20	204	204	3,978	24
25				1997	1,189		20	59	59	1,136	25
26				1998	36,145		20	1,807	1,807	33,430	26
27				1998	1,402		20	70	70	1,295	27
28				1998	3,639		20	182	182	3,367	28
29				1998	619		20	31	31	574	29
30				1999	\$ 353	\$	20	\$ 18	18	333	30
31				1999	1,000		20	50	50	925	31
32				2000	1,966		20	98	98	1,715	32
33				2000	1,072		20	54	54	945	33
34				2000	1,945		20	97	97	1,702	34
35				2000	1,072		20	54	54	945	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 Manor Nursing Home

0052993

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	\$ 2,205	37
38	Flooring	2000	1,168		20	58	58	1,015	38
39	Shades	2001	1,788		20	89	89	1,469	39
40	Painting	2001	2,228		20	111	111	1,832	40
41	Carpet	2001	4,841		20	242	242	3,993	41
42	Carpet	2001	8,000		20	400	400	6,600	42
43	Painting	2001	345		20	17	17	281	43
44	Fire System	2001	42,286		20	2,114	2,114	34,881	44
45	Carpet	2001	2,155		20	108	108	1,782	45
46	Kitchen Remodeling	2001	43,315		20	2,166	2,166	35,739	46
47	Expansion	2002	7,352		20	368	368	5,706	47
48	Wall	2002	6,000		20	300	300	4,650	48
49	New Addition	2004	3,021		20	151	151	2,040	49
50	Stairway, sunroom, new addition	2004	218,275		20	10,914	10,914	147,339	50
51	Engineering Fees	2005	2,047		20	102	102	1,275	51
52	IDPH Planning Fee	2005	2,976		20	149	149	1,862	52
53	Architect Fees	2005	1,904		20	98	98	1,221	53
54	Asphalt West Lot	2006	21,480		20	1,074	1,074	12,530	54
55	Air Conditioner	2007	3,000		10	300	300	1,127	55
56	Wheelchair Ramp	2007	930		15	62	62	651	56
57	Fencing	2008	3,634		39	94	94	893	57
58	Generator Repair	2009	3,214		7			3,214	58
59	Boiler and Mixing Valve Repair	2009	5,449		7			5,449	59
60	Boiler Repair	2009	2,582		7			2,582	60
61	Air Conditioner-Dining Room	2009	3,834		7			3,834	61
62	Roof Installation	2009	6,752		15	450	450	3,825	62
63	Sunroom	2009	10,779		35	308	308	2,618	63
64	Water Heater	2010	6,518		7	460	460	6,518	64
65	Air Conditoner Repair	2010	3,308		7	240	240	3,308	65
66	Boiler	2010	14,000		20	700	700	5,250	66
67	Carpeting, Kitchen Remodeling, Fire Alarm Replacement	2011	83,079		15	5,539	5,539	36,003	67
68	Boiler	2012	22,000		15	1,466	1,466	8,063	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,919,074	\$		\$ 147,316	\$ 70,149	\$ 2,249,845	70

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

Facility Name & ID Number Sunset Manor Nursing Home# 0052993

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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	
1	Totals from Page 12A, Carried Forward		\$ 3,919,074	\$		\$ 147,316	\$ 147,316	\$ 2,249,845	1
2	Carpeting-Lobby, A Wing, Medium Wing, Alzheimers Hall	2013	36,269		15	2,418	2,418	10,881	2
3	Furnace and Air Conditoner	2013	6,920		15	462	462	2,079	3
4	Boilers	2013	23,500		15	1,566	1,566	7,047	4
5	Roof Repair	2013	5,369		7	768	768	3,456	5
6	Elevator Replacement	2014	238,169		25	9,528	9,528	33,348	6
7	Compressor	2014	2,931		7	419	419	1,467	7
8	Furnace	2016	4,035		15	270	270	405	8
9	Water Heater	2016	10,397		7	1,486	1,486	2,229	9
10	Flooring in Office Area	2016	7,215		10	1,444	1,444	2,166	10
11	Roof Repair	2017	7,775		7	555	555	555	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	Land Improvements Booked			179			(179)		27
28	Building Booked			73,687			(73,687)		28
29	Building Improvement Booked			41,921			(41,921)		29
30									30
31	2017-Home Office Allocation-Building Improvements		15,787			379	379		31
32	2017-Home Office Allocation-Land Improvements		1,453			94	94		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,278,894	\$ 115,787		\$ 166,705	\$ 50,918	\$ 2,313,478	34

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

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Report Period Beginning:

1/1/2017

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12/31/2017

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	\$ 26,503	\$ 2,876	\$ 2,606	\$ (270)	5-10 yrs.	\$ 15,073	71
72	Current Year Purchases	14,638	2,091	2,091		7 yrs.	2,091	72
73	Fully Depreciated Assets	311,843					311,843	73
74	Home Office Allocation			19,385	19,385			74
75	TOTALS	\$ 352,984	\$ 4,967	\$ 24,082	\$ 19,115		\$ 329,007	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)	\$ 4,791,884	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,754	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 190,787	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 70,033	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,707,491	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					88
89	N/A				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.

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Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 28,641 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>Facility</u>	<u>Ford E150 Van</u>	\$ <u>578.00</u>	\$ <u>4,625</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 578.00	\$ 4,625	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 Manor Nursing Home

0052993

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 20,887
Dishwasher	701
Copier	4,699
Home Office Allocation	<u>2,354</u>
	<u><u>28,641</u></u>

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

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

<p>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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	\$	6,808	\$ 102,119	\$	6,808	\$ 102,119	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		129	1,937		129	1,937	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		10,059	150,887	87	10,059	150,974	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				34,725		34,725	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			\$	16,996	\$ 254,943	\$ 34,812	16,996	\$ 289,755	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 Manor Nursing Home# 0052993Report Period Beginning: 1/1/2017Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(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	\$ 498,574	\$ 498,574	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>85,072</u>)	1,936,363	1,936,363	3
4	Supply Inventory (priced at <u>Cost</u>)	15,021	15,021	4
5	Short-Term Investments			5
6	Prepaid Insurance	24,078	38,138	6
7	Other Prepaid Expenses	18,672	18,672	7
8	Accounts Receivable (owners or related parties)	650,131	49,213	8
9	Other(specify): <u>Prepaid Expenses</u>	97,403	97,403	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,240,242	\$ 2,653,384	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		3,248,413	14
15	Leasehold Improvements, at Historical Cost	2,931	1,030,481	15
16	Equipment, at Historical Cost	80,203	417,990	16
17	Accumulated Depreciation (book methods)	(69,428)	(2,707,491)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		161,628	20
21	Restricted Funds		404,887	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,706	\$ 2,650,908	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,253,948	\$ 5,304,292	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 745,352	\$ 745,352	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,333	124,333	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,125	9,125	31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,824	32
33	Accrued Interest Payable		8,150	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	139,167	139,167	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,017,977	\$ 1,069,951	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,540,387	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	3,054	3,054	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,054	\$ 2,543,441	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,021,031	\$ 3,613,392	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,232,917	\$ 1,690,900	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,253,948	\$ 5,304,292	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,500,957	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Report Was Filed	(1,877)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,499,080	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	733,837	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)	\$ 733,837	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)	\$ 2,232,917	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunset Manor Nursing Home

0052993

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,705,603	1
2	Discounts and Allowances for all Levels	(208,852)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,496,751	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	460,662	6
7	Oxygen	744	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 461,406	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	46,258	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,941	20
21	Other Medical Services	12,823	21
22	Laundry	210	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 120,770	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(6)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (6)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	3,242	28
28a	<u>Miscellaneous & Meals on Wheels Revenue</u>	509	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,751	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,082,672	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	902,648	31
32	Health Care	1,984,215	32
33	General Administration	670,107	33
B. Capital Expense			
34	Ownership	360,916	34
C. Ancillary Expense			
35	Special Cost Centers	168,039	35
36	Provider Participation Fee	262,910	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,348,835	40
41	Income before Income Taxes (line 30 minus line 40)**	733,837	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 733,837	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,346,491	44
45	Private Pay - Net Inpatient Revenue	900,224	45
46	Medicare - Net Inpatient Revenue	239,134	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	10,902	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,496,751	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 Manor Nursing Home

0052993

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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	2,548	2,789	\$ 70,460	\$ 25.26	1
2	Assistant Director of Nursing	2,280	2,280	51,333	22.51	2
3	Registered Nurses	7,080	7,396	175,986	23.79	3
4	Licensed Practical Nurses	19,392	20,209	376,178	18.61	4
5	CNAs & Orderlies	58,673	60,307	734,904	12.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,028	2,080	21,595	10.38	9
10	Activity Assistants	2,508	2,622	17,991	6.86	10
11	Social Service Workers	1,995	1,995	27,069	13.57	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,251	12.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,245	13,865	142,006	10.24	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	34,966	16.81	17
18	Housekeepers	22,695	23,733	241,591	10.18	18
19	Laundry	1,726	1,794	16,601	9.25	19
20	Administrator	2,080	2,080	62,000	29.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,287	2,287	31,176	13.63	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>Page 20A</u>	7,768	7,916	155,161	19.60	33
34	TOTAL (lines 1 - 33)	150,465	155,513	\$ 2,185,268 *	\$ 14.05	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	30	\$ 1,534	L1, C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,102	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)	30	\$ 28,636		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	68	\$ 2,195	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	68	\$ 2,195		53

Sunset Manor Nursing Home

0052993

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,917	3,917	99,169	25.32
Transportation	1,771	1,919	21,994	11.46
Marketing	2,080	2,080	33,998	16.35
TOTAL	7,768	7,916	155,161	

Sunset Manor Nursing Home

0052993

Period Beginning

1/1/2017

Period End

12/31/2017

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

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,363
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	277
Arnstein & Lehr	Legal	1863
SB2	Legal	1171
Miscellaneous	Legal	22
Miller Hall and Triggs	Legal	296
Smith Amundsen	Legal	115
Healthcare Resources International	Legal	205
Hunziker Law	Legal	2
Lexis Nexis	Legal	12
Baker Tilly Virchow Krause	Legal	1040
Capital Finance Group	Legal	250
CliftonLarsonAllen	Accounting	5596
Ginoli & Co.	Accounting	4844
Baker Tilly Virchow Krause	Accounting	208
Breslin and Young	Accounting	4903
Capital Finance Group	Accounting	4525
Miscellaneous	Computer Services	155
Change Healthcare	Computer Services	13
360 Networks	Computer Services	64
Matrix Care	Computer Services	5807
Stratus Networks	Computer Services	693
Kemper Technology	Computer Services	393
AT&T	Computer Services	10
Ability Network	Computer Services	428
CIAN	Computer Services	483
Comcast	Computer Services	27
CCH	Computer Services	24
Charter Communications	Computer Services	48
Allscripts	Computer Services	430
ATS	Computer Services	442
Citrix Systems	Computer Services	41
Optimizer	Other Prof Fees	78
Ankura	Other Prof Fees	1250
David Budde	Other Prof Fees	58
Sargent Consulting	Other Prof Fees	3475
Alix Partners	Other Prof Fees	25462
Demonica Kemper	Other Prof Fees	51
Brad Barkley	Other Prof Fees	204
MPAC Healthcare	Other Prof Fees	31
Higgs Appraisal	Other Prof Fees	14
Alan Litwiller	Other Prof Fees	5
Total (agree to Schedule V, line 19, column 8)		<u>71,378</u>

Facility Name & ID Number Sunset Manor Nursing Home# 0052993

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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-\$952
- (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. \$ 33,416 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. \$ 262,910
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. \$ 8,026
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 3,242
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. No
Attach invoices and a summary of services for all architect and appraisal fees