FOR BHF USE

LL1

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0011643

Facility Name: Sunset Home

Address: 418 Washington St (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 223-2636 **Fax #** (217) 223-9867

HFS ID Number:

Date of Initial License for Current Owners: N/A

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Andrew Cutler **Telephone Number:** (847) 374-0400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/15 to 09/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 374-0400 Fax # (847) 964-5469

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	182	Skilled (SNF)	182	66,612	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	182	TOTALS	182	66,612	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,060	6,060	8
9	SNF/PED					9
10	ICF	28,254	16,675	1,390	46,319	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,254	16,675	7,450	52,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.63%

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)
Indivdual Living Units Senior Apartments

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 182 and days of care provided 5,597

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30 Fiscal Year: 09/30

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	548,409	40,031	17,023	605,463		605,463		605,463			1
2	Food Purchase		434,986		434,986		434,986	(11,341)	423,645			2
3	Housekeeping	273,268	32,336	5,607	311,211		311,211		311,211			3
4	Laundry	48,345	4,005	169,043	221,393		221,393		221,393			4
5	Heat and Other Utilities			307,142	307,142		307,142		307,142			5
6	Maintenance	120,217	48,490	110,276	278,983		278,983	(29,515)	249,468			6
7	Other (specify):*											7
8	TOTAL General Services	990,239	559,848	609,091	2,159,178		2,159,178	(40,856)	2,118,322			8
	B. Health Care and Programs											
9	Medical Director			6,715	6,715		6,715		6,715			9
10	Nursing and Medical Records	4,133,702	242,421	11,943	4,388,066		4,388,066		4,388,066			10
10a	Therapy											10a
11	Activities	158,956	12,605	8,945	180,506		180,506		180,506			11
12	Social Services	164,891	4,255	16,833	185,979		185,979		185,979			12
13	CNA Training											13
14	Program Transportation			450	450		450		450			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,457,549	259,281	44,886	4,761,716		4,761,716		4,761,716			16
	C. General Administration											
17	Administrative	104,114			104,114		104,114		104,114			17
18	Directors Fees											18
19	Professional Services			142,811	142,811		142,811	(6,000)	136,811			19
20	Dues, Fees, Subscriptions & Promotions			173,405	173,405		173,405	(96,608)	76,797			20
21	Clerical & General Office Expenses	416,736	25,187	330,184	772,107		772,107	(324,000)	448,107			21
22	Employee Benefits & Payroll Taxes			1,778,686	1,778,686		1,778,686		1,778,686			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,929	17,929		17,929		17,929			24
25	Other Admin. Staff Transportation			20,698	20,698		20,698	(2,328)	18,370			25
26	Insurance-Prop.Liab.Malpractice			86,604	86,604		86,604		86,604			26
27	Other (specify):*											27
28	TOTAL General Administration	520,850	25,187	2,550,317	3,096,354		3,096,354	(428,936)	2,667,418			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,968,638	844,316	3,204,294	10,017,248		10,017,248	(469,792)	9,547,456			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 Home #0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			600,988	600,988		600,988	(3,001)	597,987			30
31	Amortization of Pre-Op. & Org.			6,549	6,549		6,549		6,549			31
32	Interest			96,649	96,649		96,649	(96,649)				32
33	Real Estate Taxes			956	956		956	(24)	932			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			705,142	705,142		705,142	(99,674)	605,468			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,883	440,023	651,906		651,906		651,906			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			20,427	20,427		20,427	(20,427)				41
42	Provider Participation Fee			379,130	379,130		379,130		379,130			42
43	Other (specify):*	126,639		490,041	616,680		616,680	(490,041)	126,639			43
44	**TOTAL Special Cost Centers**	126,639	211,883	1,329,621	1,668,143		1,668,143	(510,468)	1,157,675			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,095,277	1,056,199	5,239,057	12,390,533		12,390,533	(1,079,934)	11,310,599			45

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,341)	02		4
5	Telephone, TV & Radio in Resident Rooms	(29,515)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,001)	30		9
10	Interest and Other Investment Income	(47,979)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions	(4,580)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(241,279)	21		24
25	Fund Raising, Advertising and Promotional	(96,608)	20		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	(650,211)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,084,514)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,084,514)		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 Yes	2 No	3 Amount	4 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

Sunset Home

ID# 0011643

Report Period Beginning: 10/01/15

Ending: 09/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Investment Change In Market Value	$ (48,670)	32	1
2	Cost of Cerammics	(36)	41	2
3	Cost of Handi Rack	(4,682)	41	3
4	Sunset Clothing Sales	(3,428)	41	4
5	Cost of Ice Cream Shoppe	(12,281)	41	5
6	Meeting Room rentals	(125)	21	6
7	Villa Expense	(110,993)	43	7
8	Apartment Expense	(364,194)	43	8
9	Marketing Salary	(52,806)	21	9
10	Misc. Income	(29,790)	21	10
11	Change in Split Income Agreement	(14,854)	43	11
12	Non-Allowable R/E Tax Late Fees	(24)	33	12
13	Adjustment To Legal Expense	(6,000)	19	13
14	Non-Allowable Travel Expense	(2,328)	25	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**	(650,211)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,341)	0	0	0	0	0	0	0	0	0	0	(11,341)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(29,515)	0	0	0	0	0	0	0	0	0	0	(29,515)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(40,856)	0	0	0	0	0	0	0	0	0	0	(40,856)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	19
20	Fees, Subscriptions & Promotions	(96,608)	0	0	0	0	0	0	0	0	0	0	(96,608)	20
21	Clerical & General Office Expenses	(324,000)	0	0	0	0	0	0	0	0	0	0	(324,000)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,328)	0	0	0	0	0	0	0	0	0	0	(2,328)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(428,936)	0	0	0	0	0	0	0	0	0	0	(428,936)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(469,792)	0	0	0	0	0	0	0	0	0	0	(469,792)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunset Home # 0011643 **Report Period Beginning:** 10/01/15 **Ending:** 09/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,001)	0	0	0	0	0	0	0	0	0	0	(3,001)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(96,649)	0	0	0	0	0	0	0	0	0	0	(96,649)	32
33	Real Estate Taxes	(24)	0	0	0	0	0	0	0	0	0	0	(24)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(99,674)	0	0	0	0	0	0	0	0	0	0	(99,674)	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	(20,427)	0	0	0	0	0	0	0	0	0	0	(20,427)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(490,041)	0	0	0	0	0	0	0	0	0	0	(490,041)	43
44	**TOTAL Special Cost Centers**	(510,468)	0	0	0	0	0	0	0	0	0	0	(510,468)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,079,934)	0	0	0	0	0	0	0	0	0	0	(1,079,934)	45

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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

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 [X] NO

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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								1
2								2
3								3
4								4
5								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 Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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	See Attached List of Board of Directors								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										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	TOTALS					$	$		$	25

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	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	Peoples Prosperity Bank		X	Renovation		12/1/13	$ 6,000,000	$ 5,342,720	12/27/2033	0.0254	$ 89,001	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Peoples Prosperity Bank		X	Working Capital				750,000		0.0350	7,648	6
7												7
8												8
9	TOTAL Facility Related						$ 6,000,000	$ 6,092,720			$ 96,649	9
	B. Non-Facility Related*											
10	Interest/Investment Income		X								(96,649)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (96,649)	14
15	TOTALS (line 9+line14)						$ 6,000,000	$ 6,092,720			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	932	2
3. Under or (over) accrual (line 2 minus line 1).	$	932	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	932	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	901	8
2012	903	9
2013	915	10
2014	900	11
2015	932	12

Facility Does Not Accrue R/E Taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunset Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT Andrew Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 964-5469

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-2-0917-000-00	Vacant Lot	$ 111.02	$ 111.02
2.	23-2-0926-000-00	Vacant Lot	$ 217.88	$ 217.88
3.	23-2-0971-000-00	Vacant Lot	$ 157.52	$ 157.52
4.	23-2-0972-000-00	Vacant Lot	$ 52.04	$ 52.04
5.	23-2-0973-000-00	Vacant Lot	$ 52.04	$ 52.04
6.	23-2-0974-000-00	Vacant Lot	$ 88.82	$ 88.82
7.	23-2-0975-000-00	Vacant Lot	$ 154.74	$ 154.74
8.	23-2-0979-000-00	Vacant Lot	$ 97.84	$ 97.84
9.			$	$
10.			$	$
		TOTALS	$ 931.90	$ 931.90

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 Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [X] (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? [X] (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).

Villa Aprtments, 16 2 Bedroom Units - 16,000 Square Feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	199,487		$ 102,419	1
2	Parking Lot Addition	15,000	1996-1997	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1958	1958	$ 354,000	$	50	$	$	$ 354,000	4
5	51		1971	1971	1,218,562		50	24,371	24,371	1,096,677	5
6	49		1972	1972	472,577		50	9,452	9,452	422,965	6
7	5		1987	1987	68,497		50			68,497	7
8	43		2000	2000	2,500,281		50	50,006	50,006	1,083,457	8
	Improvement Type**										
9	Various		1958		12,000		20			12,000	9
10	Various		1971		814,827		20			814,827	10
11	Various		1972		304,188		20	1,023	1,023	298,062	11
12	Various		1975		2,807		20			2,807	12
13	Various		1977		14,179		20			14,179	13
14	Various		1978		723,324		20	8,842	8,842	621,754	14
15	Various		1979		34,002		20	273	273	30,597	15
16	Various		1980		771		20			771	16
17	Various		1981		3,742		20			3,742	17
18	Various		1982		13,900		20			13,900	18
19	Various		1983		14,951		20			14,951	19
20	Various		1984		23,531		20			23,531	20
21	Various		1985		389,702		20	6,800	6,800	330,640	21
22	Various		1986		13,909		20			13,909	22
23	Various		1987		334,206		20			334,206	23
24	Various		1988		44,477		20			44,477	24
25	Various		1989		103,784		20			103,784	25
26	Various		1990		36,949		20			36,949	26
27	Various		1992		68,087		20			68,087	27
28	Various		1993		290,781		20			290,781	28
29	Various		1994		9,466		20			9,466	29
30	Various		1995		306,267		20	6,385	6,385	312,652	30
31	Various		1996		35,920		20	1,255	1,255	36,100	31
32	Various		1997		396,712		20	18,572	18,572	386,491	32
33	Various		1998		280,005		20	13	13	260,288	33
34	Various		1999		54,659		20			54,411	34
35	Various		2000		320,831		20			268,305	35
36	Various		2001		66,692		20			58,766	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 Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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	
37	Various	2002	$ 130,594	$	20	$ 5,333	$ 5,333	$ 120,840	37
38	Various	2003	113,479		20	6,731	6,731	88,800	38
39	Various	2004	161,608		20	9,640	9,640	122,854	39
40	Various	2005	51,320		20	3,203	3,203	42,086	40
41	Various	2006	99,854		20	6,017	6,017	62,601	41
42	Various	2007	2,851,356		20	117,215	117,215	1,111,813	42
43	Various	2008	24,923		20	1,662	1,662	14,125	43
44	Various	2009	40,403		20	3,004	3,004	22,529	44
45	Various	2010	15,535		20	1,122	1,122	7,292	45
46	Various	2011	44,611		20	3,371	3,371	19,144	46
47	Various	2012	359,755		20	59,034	59,034	75,891	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			600,988			(600,988)		69
70	TOTAL (lines 4 thru 69)		$ 13,222,024	$ 600,988		$ 343,324	$ (257,664)	$ 9,174,004	70

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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		$ 13,222,024	$ 600,988		$ 343,324	$ (257,664)	$ 9,174,004	1
2	Downstairs Therapy Rooms Replace Ceiling	2013	7,484		20	374	374	1,497	2
3	Acct Office - Walls & Ceilings	2013	11,744		20	587	587	2,349	3
4	Concrete Work on New Retiaining Walls	2013	7,347		20	367	367	1,469	4
5	4 Condensing Units	2013	71,580		20	3,579	3,579	14,316	5
6	Parapet Walls-Reset of Capstone	2013	3,000		20	150	150	600	6
7	Shelves on South End of Counter Wall, Countertops	2013	7,664		20	383	383	1,533	7
8	4th Floor Nursing Station Architect & Engineering Design	2013	7,017		20	351	351	1,404	8
9	2nd Floor Dining RM Architect & Engineering	2013	6,807		20	340	340	1,361	9
10	2nd Floor Dining RM Architect & Engineering	2013	14,172		20	709	709	2,835	10
11	Elevator Repair - Otis Elevator - Reclass/Adjust Per Capital Repo	2013			20	711	711	2,845	11
12	Flag Pole Repair	2013	3,214		20	161	161	643	12
13	Est3 Fire Alarm Panel	2013	15,338		20	1,534	1,534	3,068	13
14	Expansion On The Boiler Alzheimer Unit	2013	3,083		20	154	154	308	14
15	Passenger Protection System - Elevator	2013	3,162		20	158	158	316	15
16	Elevator Repairs - Otis - Reclass/Adjust Per Capital Report	2014			20	911	911	1,822	16
17	Elevator City View	2014	29,450		20	761	761	1,522	17
18	Code Alert System	2014	32,320		20	527	527	1,054	18
19	New Boiler / South	2014	35,082		20	1,754	1,754	3,508	19
20	Replace North & South Area Roofs (City, River, and Southern)	2014	152,000		20	7,600	7,600	15,200	20
21	2nd Floor Dining RM Architectural Services R/A CAP RPT	2014			20	340	340	680	21
22	2nd Floor DR Remodel - Floors, Painting, HVAC, Plumbing Electr	2014	325,127		20	18,191	18,191	36,382	22
23	Lighting - 2nd Floor	2014	3,536		20	177	177	354	23
24	Call Systems for 3 Riverview - Reclass/Adjust Per Capital Report	2014			20	1,089	1,089	2,178	24
25	17 Overbed Lights	2014	3,698		20	185	185	370	25
26	2nd FL Bathrooms Oustide Res DR - Install Toilets, Valves, Sinks	2014	14,521		20	780	780	1,560	26
27	Replace Boiler #2	2014	54,000		20	2,000	2,000	4,000	27
28	Replace Compressor	2014	26,801		20	1,340	1,340	2,680	28
29	Administration Office Carpet	2014	4,768		20	238	238	236	29
30	Panel for Chiller	2014	3,463		20	346	346	692	30
31	Elevator Repair - Reclass/Adjust per Capital Report	2014			20	2,512	2,512	5,024	31
32	Repair Diesel Tank	2014	2,586		20	129	129	258	32
33	Boiler - Reclass/Adjust Per Capital Report	2014			20	700	700	1,400	33
34	TOTAL (lines 1 thru 33)		$ 14,070,988	$ 600,988		$ 392,462	$ (208,526)	$ 9,287,468	34

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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 12B, Carried Forward		$ 14,070,988	$ 600,988		$ 392,462	$ (208,526)	$ 9,287,468	1
2	Shower Room 3rd Floor - Floors & Walls	2015	7,813		20	391	391	782	2
3	Rooftop Paint	2015	2,650		20	133	133	266	3
4	Elevator Modernization, Louver, Hood, Conduit Wiring R/A CAP	2015	114,198		20	4,454	4,454	8,908	4
5	Beauty Shop remaodel 1RV - Plumbing, Walls, Sinks, Wiring	2015	3,463		20	173	173	346	5
6	Wash Room Flooring & Patch Hallway	2015	3,485		20	174	174	348	6
7	Haven Shower repair Water Damage	2015	2,960		20	148	148	296	7
8	Laundry Room Flooring	2015	15,810		20	791	791	1,582	8
9	Repair Condenser Leak	2015	2,790		20	140	140	280	9
10	Laundry RM - Hallway & Floor	2015	16,567		20	828	828	828	10
11	Fire Door In Haven - East Hallway	2015	2,950		20	148	148	148	11
12	Power Running From Garage to Lawn	2015	4,140		20	207	207	207	12
13	Chapel Remodel - Flooring, Lighting, Paint	2015	35,018		20	1,751	1,751	1,751	13
14	Cafeteria/SW Corner Roof Repair	2016	10,300		20	515	515	515	14
15	4CV Remodel - New Rehab Unit- Walls, Plumbing, Electrical	2016	(230,744)						15
16	Ceiling, Lights	2016	1,546,789		20	77,339	77,339	77,339	16
17	Kitchen Drain Grease Trap	2016	3,475		20	174	174	174	17
18	3CV Remodel - Lighting, Ceiling, Wiring Phone/Internet, Paint	2016	178,939		20	8,947	8,947	8,947	18
19	Leaf Releif Gutter Protection	2016	2,700		20	135	135	135	19
20	Courtyard Landscape Renovation	2016	4,872		20	244	244	244	20
21	Versa Lock Wall on 4th Street	2016	5,250		20	263	263	263	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	TOTAL (lines 1 thru 33)		$ 15,804,413	$ 600,988		$ 489,416	$ (111,572)	$ 9,390,827	34

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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	$ 1,084,283	$	$ 81,623	$ 81,623	10	$ 403,097	71
72	Current Year Purchases	116,116		11,612	11,612	10	11,612	72
73	Fully Depreciated Assets	418,193					418,193	73
74								74
75	TOTALS	$ 1,618,592	$	$ 93,234	$ 93,234		$ 832,902	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		2014 Ford Cargo Van	2014	$ 31,803	$	$ 6,361	$ 6,361	5	$ 15,902	76
77		2014 Ford F-250 - Silver	2014	26,199		5,240	5,240	5	13,100	77
78		See Attached		137,461		3,736	3,736	5	127,737	78
79										79
80	TOTALS			$ 195,463	$	$ 15,337	$ 15,337		$ 156,739	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)	$ 17,807,175	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 600,988	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 597,987	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,001)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,380,468	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	Villas - Fixed Assets -2015	$ 1,882,665	$ 58,504	$ 1,205,753	86
87	Sunset Apartments - 2012	3,162,976	98,919	1,107,046	87
88					88
89					89
90					90
91	TOTALS	$ 5,045,641	$ 157,423	$ 2,312,799	91

G. Construction-in-Progress

	Description	Cost	
92	CIP-Smoke Barriers	$ 13,022	92
93	CIP - APTS Retaining Walls	49,583	93
94			94
95		$ 62,605	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.

D - Vehicle Cost

Make, Model year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
1994 Ford Van	4/1/1995	36216				5	36216
1997 GMC 3/4 Ton Truck	11/1/1997	21541				5	21541
Snow Plow	11/1/1997	1980				5	1980
2001 E-450 Ford Bus	11/1/2001	56836				5	56836
Bus Repair	4/10/2012	759		95		5	759
Bus Repairs	08/01/212	5128		641		5	5128
Wrap for Van	6/13/2014	3881		776.2		5	1941
Truck Spreader/Back-Up Alarm Spray	10/16/2014	11120		2224		5	3336
Total on Page 13		137461		3736.2			127737

Assets Added After 6/30/16 Capital Rate

Laundry RM - Hallway & Floor	**2015**	**16,567**	
Fire Door In Haven - East Hallway	**2015**	**2,950**	
Power Running From Garage to Lawn	**2015**	**4,140**	
Chapel Remodel - Flooring, Lighting, Paint	**2015**	**35,018**	
Cafeteria/SW Corner Roof Repair	**2016**	**10,300**	
Kitchen Drain Grease Trap	**2016**	**3,475**	
3CV Remodel - Lighting, Ceiling, Wiring Pl	**2016**	**178,939**	
Leaf Releif Gutter Protection	**2016**	**2,700**	
Courtyard Landscape Renovation	**2016**	**4,872**	
Versa Lock Wall on 4th Street	**2016**	**5,250**	
Total		**264,211**	

Reclass Equipment to P. 13	**2016**	**(230,744)**	P13 Line 71
4th Floor Short Term Rehab Center	**2016**	**1,546,789**	
Total 4th Floor Short Term Rehab Center		**1,316,045**	

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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	$

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: $ Description:
(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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Sunset Home

STATE OF ILLINOIS
0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	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	39-03	hrs	$		$ 182,366	$		$ 182,366	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			22,432			22,432	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			223,648			223,648	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				211,883		211,883	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): O2 Tanks/Lab	39-03				11,577			11,577	12
13	Other (specify):									13
14	TOTAL			$		$ 440,023	$ 211,883		$ 651,906	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.

STATE OF ILLINOIS

Facility Name & ID Number Sunset Home **#** 0011643 **Report Period Beginning:** 10/01/15 **Ending:** 09/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 09/30/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 104,592	$	1
2	Cash-Patient Deposits	13,620		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (250,000))	1,825,250		3
4	Supply Inventory (priced at)	51,816		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,431		6
7	Other Prepaid Expenses	32,659		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	153,274		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,207,642	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,154,431		12
13	Land	1,588,736		13
14	Buildings, at Historical Cost	6,036,874		14
15	Leasehold Improvements, at Historical Cost	12,430,125		15
16	Equipment, at Historical Cost	4,619,301		16
17	Accumulated Depreciation (book methods)	(12,911,754)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	62,605		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,980,318	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 18,187,960	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 330,958	$	26
27	Officer's Accounts Payable	13,620		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	389,287		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,078		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 759,943	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,092,720		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	37,300		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,130,020	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,889,963	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,297,997	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 18,187,960	$	48

***(See instructions.)**

	Other Current Assets:	Amount	Amount
9	Unamortized Bond Expenses	109894	
9	Apt. Unamortized Bond Expense	43,380	
9			
9			
9			
9			
	Total Line 9	153,274	0

	Other Non-Current Assets:	Amount	Amount
23	CIP - Smoke Barriers	13,022	
23	CIP- Apts. Retaining Walls	49,583	
23			
23			
23			
23			
23			
	Total Line 23	62,605	0

	Other Current Liabilities:	Amount	Amount
36			
36			
36			
36			
36			
36			
36			
36			
	Total Line 36	0	0

	Other Non-Current Liabilities:	Amount	Amount
43	Apt. A/P Security Deposits	37300	
43			
43			
43			
43			
43			
43			
43			
	Total Line 43	37300	0

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,477,361	1
2	Restatements (describe):		2
3	**PY Rounding**	8	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,477,369	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,179,372)	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)**	$ (1,179,372)	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)**	$ 11,297,997	24 *

*** This must agree with page 17, line 47.**

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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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,539,548	1
2	Discounts and Allowances for all Levels	(155,419)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,384,129	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,255,789	6
7	Oxygen	41,569	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,297,358	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	11,341	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	187,358	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,301	19
20	Radiology and X-Ray	2,478	20
21	Other Medical Services	5,457	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 225,935	23
	D. Non-Operating Revenue		
24	Contributions	241,144	24
25	Interest and Other Investment Income***	119,766	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 360,910	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	942,829	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 942,829	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,211,161	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,159,178	31
32	Health Care	4,761,716	32
33	General Administration	3,096,354	33
	B. Capital Expense		
34	Ownership	705,142	34
	C. Ancillary Expense		
35	Special Cost Centers	1,289,013	35
36	Provider Participation Fee	379,130	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,390,533	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,179,372)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,179,372)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,894,526	44
45	Private Pay - Net Inpatient Revenue	3,406,554	45
46	Medicare - Net Inpatient Revenue	965,813	46
47	Other-(specify) Ins./MCO	117,236	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,384,129	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

Sunset Home
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10/1/2015-9/30/2016

	Description	Amount
28	Ceramic Sales	343
28	Handi Rack Sales	5,076
28	Sunset Clothing Sales	6,876
28	Ice Cream Shoppe	7,526
28	Villa Maintenance Income	11,520
28	Villa Lease Income	142,860
28	Beauty Shop Rental	1,785
28	Meeting Rooms Rental	125
28	Miscellaneous Income	29790
28	APT. Apartment Rent	653,214
28	APT. Guest Apartment Rent	5,720
28	APT. Storage Cage Rental	7,100
28	APT. Sunset Chapel Rent	1,800
28	APT. Parking Fee	6,825
28	APT. Beauty Shop Rental	1,500
28	APT. Apartment Cleaning Fee	1,300
28	APT. Carpet Cleaning Fee	100
28	APT. Forfieted Security Deposit	5,500
28	APT. Interest Income	**35**
28	APT. Other Income	53,834
	Total	942,829

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,176	2,176	$ 81,127	$ 37.28	1
2	Assistant Director of Nursing	2,208	2,208	63,525	28.77	2
3	Registered Nurses	32,094	32,094	847,329	26.40	3
4	Licensed Practical Nurses	60,577	60,577	1,104,161	18.23	4
5	CNAs & Orderlies	152,661	152,661	1,966,016	12.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,448	4,448	63,026	14.17	9
10	Activity Assistants	10,810	10,810	95,930	8.87	10
11	Social Service Workers	10,833	10,833	164,891	15.22	11
12	Dietician					12
13	Food Service Supervisor	2,208	2,208	51,771	23.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	47,592	47,592	496,638	10.44	15
16	Dishwashers					16
17	Maintenance Workers	9,407	9,407	120,217	12.78	17
18	Housekeepers	27,605	27,605	273,268	9.90	18
19	Laundry	4,171	4,171	48,345	11.59	19
20	Administrator	2,240	2,240	104,114	46.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,462	20,462	416,736	20.37	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	4,610	4,610	71,544	15.52	31
32	Other Health Care(specify)					32
33	Other(specify) Non-Care Payroll	7,879	7,879	126,639	16.07	33
34	TOTAL (lines 1 - 33)	401,981	401,981	$ 6,095,277 *	$ 15.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 17,023	1-3	35
36	Medical Director	Monthly	6,715	9-3	36
37	Medical Records Consultant	8	589	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,354	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	985	11-3	44
45	Social Service Consultant	Monthly	4,918	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	8	$ 41,584		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn St. Clair Davis	Administrator	0	$ 104,114
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,114

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FRR HC Consulting	Consulting	$ 65
See Attached	Legal	30,888
Gray Hunter Stenn. LLP	Audit	25,325
Marcum	Accounting/Consulting	9,895
Susan Hayes	Accounting Consultant	4,881
Ability	Data Processing	5,316
ADP	Data Processing	41,540
Point Click Care	Electronic Records	24,901
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 142,811

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,673
Unemployment Compensation Insurance	9,292
FICA Taxes	436,260
Employee Health Insurance	1,068,990
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	3,693
403B Employer Pension	116,537
Physicals/Drug Tests	226
Finger Printing	1,222
Perks/Gifts	30,793
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,778,686

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	13,995
Health Care Worker Background Check	
(Indicate # of checks performed 25)	250
Patient Background Checks 176	1,760
Advertising Expense	74,091
Dues & Subscriptions	56,812
Public Relations	22,517
Less: Public Relations Expense	(22,517)
Non-allowable advertising	(74,091)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 76,797

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	17,929
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,929

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/15 Ending: 09/30/16

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 - $11,739**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,421** 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. $ **379,130**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,341**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Line 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Gray Hunter Stenn, LLC**

(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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees