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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0051458

Facility Name: Sunrise Skilled Nur & Rehab

Address: 333 S Wrightsman St (Number) Virden (City) 62690 (Zip Code)

County: Macoupin

Telephone Number: (217)965-4715 **Fax #** (217)965-5530

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2011

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Carol Sparks Telephone Number: (949)349-1222
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 01/01/17 to 12/31/17 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)	Chris Joos Partner
	(Firm Name & Address)	Plante & Moran, PLLC 250 S. High Street, Suite 100
	(Telephone)	(614)222-9040 Fax # (248)233-8811

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 Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	41.00	Skilled (SNF)	41	14,965	1
2		Skilled Pediatric (SNF/PED)			2
3	58.00	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,183	4,166	2,290	11,639	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	8,408	2,551	223	11,182	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,591	6,717	2,513	22,821	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.15%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 05/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 39 and days of care provided 1,993

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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 Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	129,218	26,085	10,554	165,857		165,857		165,857			1
2	Food Purchase		118,252		118,252		118,252		118,252			2
3	Housekeeping	72,731	13,061	4,617	90,409		90,409		90,409			3
4	Laundry	27,062	4,545	60	31,667		31,667		31,667			4
5	Heat and Other Utilities			105,459	105,459		105,459		105,459			5
6	Maintenance	39,021	16,288	44,664	99,973		99,973		99,973			6
7	Other (specify):*			4,260	4,260		4,260		4,260			7
8	**TOTAL General Services**	268,032	178,231	169,614	615,877		615,877		615,877			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,393,421	60,976	48,766	1,503,163		1,503,163		1,503,163			10
10a	Therapy			461,013	461,013		461,013	(17,472)	443,541			10a
11	Activities	45,457	4,874	4,926	55,257		55,257		55,257			11
12	Social Services	64,283		19,739	84,022		84,022		84,022			12
13	CNA Training											13
14	Program Transportation			41,161	41,161		41,161		41,161			14
15	Other (specify):*							20,442	20,442			15
16	**TOTAL Health Care and Programs**	1,503,161	65,850	590,605	2,159,616		2,159,616	2,970	2,162,586			16
	C. General Administration											
17	Administrative	60,889		215,121	276,010		276,010	3,243	279,253			17
18	Directors Fees											18
19	Professional Services			105,427	105,427		105,427	(718)	104,709			19
20	Dues, Fees, Subscriptions & Promotions			21,019	21,019		21,019	(1,901)	19,118			20
21	Clerical & General Office Expenses	103,606	40,129	127,292	271,027		271,027	(84,759)	186,268			21
22	Employee Benefits & Payroll Taxes			388,427	388,427		388,427		388,427			22
23	Inservice Training & Education											23
24	Travel and Seminar			104	104		104		104			24
25	Other Admin. Staff Transportation			1,795	1,795		1,795		1,795			25
26	Insurance-Prop.Liab.Malpractice			212,968	212,968		212,968		212,968			26
27	Other (specify):*			133,403	133,403		133,403	(11,153)	122,250			27
28	**TOTAL General Administration**	164,495	40,129	1,205,556	1,410,180		1,410,180	(95,288)	1,314,892			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,935,688	284,210	1,965,775	4,185,673		4,185,673	(92,318)	4,093,355			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.

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			101,725	101,725		101,725	73,997	175,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							27,184	27,184			32
33	Real Estate Taxes			29,239	29,239		29,239	194	29,433			33
34	Rent-Facility & Grounds			94,626	94,626		94,626	(94,626)				34
35	Rent-Equipment & Vehicles			44,095	44,095		44,095		44,095			35
36	Other (specify):*			135	135		135	(135)				36
37	TOTAL Ownership			269,820	269,820		269,820	6,614	276,434			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,346	83,899	94,245		94,245		94,245			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,628	180,628		180,628		180,628			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		10,346	264,527	274,873		274,873		274,873			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,935,688	294,556	2,500,122	4,730,366		4,730,366	(85,704)	4,644,662			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 Sunrise Skilled Nur & Rehab **#** 0051458 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(12)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,717)	21		24
25	Fund Raising, Advertising and Promotional	(11,153)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(135)			26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(22,074)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,091)		$	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)	(94,626)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (94,626)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (210,717)		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

STATE OF ILLINOIS

Sunrise Skilled Nur & Rehab

ID# 0051458

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Bank Charges	(953)	21	3
4	Business Taxes	(135)	36	4
5	Prior Year Expenses	(1,089)	21	5
6	Real Estate Taxes	194	33	6
7	Non Allowable Dues	(1,901)	20	7
8	Non Allowable Legal Fees	(718)	19	8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(4,602)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	(17,472)	0	0	0	0	0	0	0	0	(17,472)	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	20,442	0	0	0	0	0	0	0	20,442	15
16	**TOTAL Health Care and Programs**	0	0	(17,472)	20,442	0	0	0	0	0	0	0	2,970	16
	C. General Administration													
17	Administrative	0	0	0	3,243	0	0	0	0	0	0	0	3,243	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(718)	0	0	0	0	0	0	0	0	0	0	(718)	19
20	Fees, Subscriptions & Promotions	(1,901)	0	0	0	0	0	0	0	0	0	0	(1,901)	20
21	Clerical & General Office Expenses	(84,759)	0	0	0	0	0	0	0	0	0	0	(84,759)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(11,153)	0	0	0	0	0	0	0	0	0	0	(11,153)	27
28	**TOTAL General Administration**	(98,531)	0	0	3,243	0	0	0	0	0	0	0	(95,288)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(98,531)	0	(17,472)	23,685	0	0	0	0	0	0	0	(92,318)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	53,387	0	20,610	0	0	0	0	0	0	0	73,997	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12)	0	0	27,196	0	0	0	0	0	0	0	27,184	32
33	Real Estate Taxes	194	0	0	0	0	0	0	0	0	0	0	194	33
34	Rent-Facility & Grounds	0	(94,626)	0	0	0	0	0	0	0	0	0	(94,626)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(135)	0	0	0	0	0	0	0	0	0	0	(135)	36
37	**TOTAL Ownership**	47	(41,239)	0	47,806	0	0	0	0	0	0	0	6,614	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(98,484)	(41,239)	(17,472)	71,491	0	0	0	0	0	0	0	(85,704)	45

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 94,626	CC Virden, LLC	100.00%	$	$ (94,626)	1
2	V	30	Depreciation		CC Virden, LLC	100.00%	53,387	53,387	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			$ 94,626			$ 53,387	$ * (41,239)	14

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Physical Therapy	$ 199,376	Affirma Rehabilitation	100.00%	$ 191,820	$ (7,556)	15
16	V	10a	Occupational Therapy	200,901	Affirma Rehabilitation	100.00%	193,287	(7,614)	16
17	V	10a	Speech Therapy	60,736	Affirma Rehabilitation	100.00%	58,434	(2,302)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 461,013			$ 443,541	$ * (17,472)	39

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	43	NonAllow	$	Covenant Care California, LLC	100.00%	$ 0	$	15
16	V	15	Direct		Covenant Care California, LLC	100.00%	20,442	20,442	16
17	V	17	Indirect		Covenant Care California, LLC	100.00%	218,364	218,364	17
18	V	32	Interest		Covenant Care California, LLC	100.00%	27,196	27,196	18
19	V	30	Depreciation		Covenant Care California, LLC	100.00%	20,610	20,610	19
20	V	17	Management Fees	215,121	Covenant Care California, LLC	100.00%		(215,121)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 215,121			$ 286,612	$ * 71,491	39

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	COVENANT CARE CALIFORNIA, LLC	100.00%	ARBOR NURSING CENTER	CALIFORNIA	CC VIRDEN LLC	VIRDEN, IL	BUILDING CO	1
2			ARBOR PLACE	CALIFORNIA	COVENANT CARE CALIFORNIA, LLC		MANAGEMENT C	2
3			BUENA VISTA CARE CENTER, A NURSING	CALIFORNIA	AFFIRMA REHABILITATION		THERAPY	3
4			CARSON NURSING & REHAB CENTER	NEVADA				4
5			CATERED MANOR	CALIFORNIA				5
6			CLINTON HOUSE HEALTH & REHABILITA	INDIANA				6
7			COURTYARD HEALTHCARE CENTER	CALIFORNIA				7
8			COVENANT CARE HILLTOP, LLC D/B/A HI	CHARLESTON				8
9			COVENANT CARE JACKSONVILLE, LLC D/	JACKSONVILLE				9
10			COVENANT CARE MEADOW MANOR, LLC	TAYLORVILLE				10
11			COVENANT CARE MIDWEST, INC. D/B/A C	LEBANON				11
12			COVENANT CARE SUNRISE, LLC D/B/A SU	VIRDEN				12
13			COVINGTON MANOR	INDIANA				13
14			DOWNEY CARE	CALIFORNIA				14
15			EAGLE POINT NURSING & REHAB CENTE	IOWA				15
16			EDGEWOOD MANOR NURSING CENTER	OHIO				16
17			EMERALD GARDENS NURSING CENTER	CALIFORNIA				17
18			ENCINITAS NURSING AND REHABILITATI	CALIFORNIA				18
19			ENNOBLE SKILLED NURSING & REHAB C	IOWA				19
20			FAIRVIEW MANOR NURSING CENTER	OHIO				20
21			FRIENDSHIP HOME	CARLINVILLE, IL				21
22			GILROY HEALTHCARE & REHABILITATIC	CALIFORNIA				22
23			GRANT CUESTA NURSING & REHABILITA	CALIFORNIA				23
24			HIGHLAND HEALTH CARE CENTER	ILLINOIS				24
25			HUNTINGTON PARK NURSING CENTER	CALIFORNIA				25
26			LA JOLLA NURSING AND REHABILITATIO	CALIFORNIA				26
27			LAKELAND NURSING CENTER	INDIANA				27
28			LOS ALTOS SUB-ACUTE & REHABILITATI	CALIFORNIA				28
29			MISSION SKILLED NURSING & SUBACUTE	CALIFORNIA				29
30			NEBRASKA SKILLED NURSING CENTER	NEBRASKA				30

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			NORWOOD NURSING CENTER	INDIANA				1
2			PACIFIC COAST MANOR	CALIFORNIA				2
3			PACIFIC GARDENS NURSING & REHABILI	CALIFORNIA				3
4			PACIFIC HILLS MANOR	CALIFORNIA				4
5			PALO ALTO NURSING CENTER	CALIFORNIA				5
6			ROYAL CARE SKILLED NURSING CENTER	CALIFORNIA				6
7			SHORELINE CARE CENTER	CALIFORNIA				7
8			SILVER HILLS HEALTH CARE CENTER	NEVADA				8
9			SILVER RIDGE HEALTHCARE CENTER	NEVADA				9
10			ST. EDNA SUBACUTE & REHABILITATION	CALIFORNIA				10
11			THE RESIDENCE AT MCCORMICK'S CREE	INDIANA				11
12			TURLOCK NURSING AND REHABILITATIO	CALIFORNIA				12
13			TURLOCK RESIDENTIAL	CALIFORNIA				13
14			UNIVERSITY PARK NURSING CENTER	INDIANA				14
15			VALLE VISTA CONVALESCENT CENTER	CALIFORNIA				15
16			VERSAILLES HEALTH CARE CENTER	OHIO				16
17			VILLA GEORGETOWN	OHIO				17
18			VILLA SPRINGFIELD	OHIO				18
19			VINTAGE FAIRE NURSING & REHABILITA	CALIFORNIA				19
20			VINTAGE FAIRE RESIDENTIAL	CALIFORNIA				20
21			WAGNER HEIGHTS NURSING & REHABILI	CALIFORNIA				21
22			WAGNER HEIGHTS RESIDENTIAL	CALIFORNIA				22
23			WALDRON HEALTH AND REHAB CENTER	INDIANA				23
24			WILLOW TREE NURSING & REHABILITAT	CALIFORNIA				24
25			WRIGHT NURSING & REHAB CENTER (VII	OHIO				25
26			MARION REHAB AND ASSISTED LIVING C	INDIANA				26
27			PYRAMID POINT POST ACUTE REHABILIT	INDIANA				27
28								28
29								29
30								30

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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								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 Sunrise Skilled Nur & Rehab # 0051458 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 X NO

Name of Related Organization: Affirma Rehabilitation
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (888)468-4372
Fax Number: ( )

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

	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	39	Physical Therapy	Direct Allocation			$	$		$ 191,820	1
2	39	Occupational Therapy	Direct Allocation						193,287	2
3	39	Speech Therapy	Direct Allocation						58,434	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					$	$		$ 443,541	25

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] NO [ ]

Name of Related Organization: Covenant Care California, LLC
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949)349-1200
Fax Number: (949)349-1900

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

	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	43	NonAllow	Accumulated Cost			$	$		$	1
2	15	Direct	Accumulated Cost						20,442	2
3	17	Indirect	Accumulated Cost						218,364	3
4	32	Interest	Accumulated Cost						27,196	4
5	30	Depreciation	Accumulated Cost						20,610	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					$	$		$ 286,612	25

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Covenant Care Califor		X								27,196	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 27,196	9
	B. Non-Facility Related*											
10	Interest Income		X								(12)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12)	14
15	TOTALS (line 9+line14)						$	$			$ 27,184	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 Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2016 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.)	$	29,433	2
3. Under or (over) accrual (line 2 minus line 1).	$	29,433	3
4. Real Estate Tax accrual used for 2017 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	$	29,433	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2012	28,000	8
2013	27,341	9
2014	27,669	10
2015	28,102	11
2016	29,433	12

Facility does not accrue for real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunrise Skilled Nur & Rehab COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0051458

CONTACT PERSON REGARDING THIS REPORT Carol Sparks

TELEPHONE (949)349-1222 FAX #: (949) 349-1122

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-000-148-01	Long Term Care Property	$ 29,432.64	$ 29,432.64
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 29,432.64	$ 29,432.64

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation***. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,444 **B.** General Construction Type: Exterior Masonry Frame Wood & Steel Number of Stories 1

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

None

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	99		2015	1970	$ 595,949	$	35	$ 17,027	$ 17,027	$ 51,081	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	74,586		20	4,129	4,129	28,901	9
10	Various			2012	399,177		20	17,101	17,101	102,606	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

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)					19,865	19,865	49,662	67
68	Related Party Allocations (Pages 12H & 12I)					20,610	20,610		68
69	Financial Statement Depreciation					41,133	41,133	171,153	69
70	TOTAL (lines 4 thru 69)		$ 1,069,712	$		$ 119,865	$ 119,865	$ 403,403	70

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 1,069,712	$		$ 119,865	$ 119,865	$ 403,403	1
2	Four Graber Lake Forest 2" Faux Wood Blinds	2013	3,334		20	167	167	834	2
3	Generator	2013	24,299		20	1,215	1,215	6,075	3
4	Hvac Repair	2014	3,906		20	195	195	781	4
5	7.5 Ton A/C Unit	2014	4,650		20	233	233	931	5
6	Wall Guards/Cove Base- East,Ne,Nw Wings, North Hall	2014	6,692		20	335	335	1,339	6
7	Wanderguard System	2015	19,970		20	999	999	2,996	7
8	6 Ptac Units	2015	10,676		20	534	534	1,602	8
9	Grease Trap Replacement	2016	3,169		20	158	158	316	9
10	Earthwork/Asphalt Paving/Flooring/Siding/Gutters Replacement	2016	135,162		20	6,758	6,758	13,516	10
11	Install New Valves & Couplings For Fire Sprinkler	2016	2,850		20	142	142	284	11
12	Toilet for Restroom	2017	671		10	50	50	50	12
13	Motors for 6 PTAC units	2017	2,991		7	249	249	249	13
14	Repair of 41 PTAC Units	2017	59,691		7	4,264	4,264	4,264	14
15	Drain line repair, replace Toilet	2017	2,370		7	113	113	113	15
16	Water Heater	2017	5,171		7				16
17	Replace Boiler Pump	2017	1,655		7				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	TOTAL (lines 1 thru 33)		$ 1,356,968	$		$ 135,277	$ 135,277	$ 436,753	34

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 198,952	$	$ 39,811	$ 39,811		$ 101,987	71
72	Current Year Purchases	3,805		634	634	5	634	72
73	Fully Depreciated Assets	137,616					137,616	73
74								74
75	TOTALS	$ 340,373	$	$ 40,445	$ 40,445		$ 240,237	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				$	$	$	$	7	$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,697,341	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 175,722	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 175,722	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 676,990	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					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number: Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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:				$ 94,626			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 94,626 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 33,655 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Van	$	$	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.

Company	Locn	Dept	Account	Journal_Desc	Amount	Month	Year	JournalNum	ApplyDate
CCMIDWST	074	6110	60000620	Acc 10/17	235	10	2017	JRNL0018	10/31/17
CCMIDWST	074	6110	60000620	Acc 10/17	(235)	11	2017	JRNL0019	11/30/17
CCMIDWST	074	6110	60000620	Acc 11/17	450	11	2017	JRNL0019	11/30/17
CCMIDWST	074	6110	60000620	Acc 11/17	(450)	12	2017	JRNL0019	12/31/17
CCMIDWST	074	6110	60000620	Acc 11/17	228	11	2017	JRNL0019	11/30/17
CCMIDWST	074	6110	60000620	Acc 11/17	(228)	12	2017	JRNL0019	12/31/17
CCMIDWST	074	6110	60000620	Acc 12/17	465	12	2017	JRNL0019	12/31/17
CCMIDWST	074	6110	60000620	Acc 12/17	235	12	2017	JRNL0019	12/31/17
CCMIDWST	074	6110	60000620	Acc ISV-Jc	228	9	2017	JRNL0018	09/30/17
CCMIDWST	074	6110	60000620	Acc ISV-Jc	(228)	10	2017	JRNL0018	10/31/17
CCMIDWST	074	6110	60000620	Acc ISV-Jc	450	9	2017	JRNL0018	09/30/17
CCMIDWST	074	6110	60000620	Acc ISV-Jc	(450)	10	2017	JRNL0018	10/31/17
CCMIDWST	074	6110	60000620	AMERICAI	195	6	2017	JRNL0018	06/30/17
CCMIDWST	074	6110	60000620	CR-SMS C	(24)	7	2017	JRNL0018	07/31/17
CCMIDWST	074	6110	60000620	ISAVE - JC	450	10	2017	JRNL0018	10/09/17
CCMIDWST	074	6110	60000620	ISAVE - JC	228	10	2017	JRNL0018	10/09/17
CCMIDWST	074	6110	60000620	ISAVE - JC	235	11	2017	JRNL0019	11/06/17
CCMIDWST	074	6110	60000620	ISAVE - JC	450	12	2017	JRNL0019	12/11/17
CCMIDWST	074	6110	60000620	ISAVE - JC	228	12	2017	JRNL0019	12/11/17
CCMIDWST	074	6110	60000620	JOERNS H	499	4	2017	JRNL0018	04/20/17
CCMIDWST	074	6110	60000620	JOERNS H	483	5	2017	JRNL0018	05/22/17
CCMIDWST	074	6110	60000620	JOERNS H	147	5	2017	JRNL0018	05/22/17
CCMIDWST	074	6110	60000620	JOERNS H	147	5	2017	JRNL0018	05/22/17
CCMIDWST	074	6110	60000620	JOERNS H	147	5	2017	JRNL0018	05/22/17
CCMIDWST	074	6110	60000620	JOERNS H	177	5	2017	JRNL0018	05/22/17
CCMIDWST	074	6110	60000620	JOERNS H	183	6	2017	JRNL0018	06/30/17
CCMIDWST	074	6110	60000620	JOERNS H	183	6	2017	JRNL0018	06/30/17
CCMIDWST	074	6110	60000620	JOERNS H	499	6	2017	JRNL0018	06/30/17
CCMIDWST	074	6110	60000620	JOERNS H	195	6	2017	JRNL0018	06/30/17
CCMIDWST	074	6110	60000620	JOERNS H	183	6	2017	JRNL0018	06/30/17
CCMIDWST	074	6110	60000620	JOERNS H	183	6	2017	JRNL0018	06/30/17
CCMIDWST	074	6110	60000620	JOERNS H	118	7	2017	JRNL0018	07/25/17
CCMIDWST	074	6110	60000620	JOERNS H	483	7	2017	JRNL0018	07/25/17
CCMIDWST	074	6110	60000620	JOERNS H	153	7	2017	JRNL0018	07/25/17
CCMIDWST	074	6110	60000620	JOERNS H	153	7	2017	JRNL0018	07/25/17
CCMIDWST	074	6110	60000620	JOERNS H	153	7	2017	JRNL0018	07/25/17
CCMIDWST	074	6110	60000620	JOERNS H	106	7	2017	JRNL0018	07/25/17
CCMIDWST	074	6110	60000620	JOERNS H	465	8	2017	JRNL0018	08/25/17
CCMIDWST	074	6110	60000620	JOERNS H	235	8	2017	JRNL0018	08/25/17
CCMIDWST	074	6110	60000620	JOERNS H	209	12	2017	JRNL0019	12/31/17
CCMIDWST	074	6110	60000620	JOERNS H	465	12	2017	JRNL0019	12/31/17
CCMIDWST	074	6110	60000620	JOERNS H	235	12	2017	JRNL0019	12/31/17
CCMIDWST	074	6110	60000620	Rcl Equip I	183	4	2017	JRNL0018	04/30/17
CCMIDWST	074	6110	60000620	SPECIALIZ	597	4	2017	JRNL0018	04/29/17
CCMIDWST	074	6200	60000620	WHEELER	75	1	2017	JRNL0018	01/26/17
CCMIDWST	074	6500	60000620	ECOLAB -	76	12	2017	JRNL0019	12/21/17
CCMIDWST	074	6500	60000620	ECOLAB -	76	11	2017	JRNL0019	11/27/17
CCMIDWST	074	6500	60000620	ECOLAB -	76	10	2017	JRNL0018	10/21/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	9	2017	JRNL0018	09/22/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	8	2017	JRNL0018	08/18/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	7	2017	JRNL0018	07/25/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	6	2017	JRNL0018	06/22/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	5	2017	JRNL0018	05/22/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	4	2017	JRNL0018	04/20/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	3	2017	JRNL0018	03/29/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	2	2017	JRNL0018	02/28/17
CCMIDWST	074	6500	60000620	ECOLAB -	74	1	2017	JRNL0018	01/20/17
CCMIDWST	074	6901	60000620	KONICA M	240	12	2017	JRNL0019	12/26/17
CCMIDWST	074	6901	60000620	KONICA M	158	12	2017	JRNL0019	12/26/17
CCMIDWST	074	6901	60000620	KONICA M	230	11	2017	JRNL0019	11/30/17
CCMIDWST	074	6901	60000620	KONICA M	148	11	2017	JRNL0019	11/30/17
CCMIDWST	074	6901	60000620	KONICA M	230	10	2017	JRNL0018	10/21/17
CCMIDWST	074	6901	60000620	KONICA M	148	10	2017	JRNL0018	10/21/17
CCMIDWST	074	6901	60000620	KONICA M	230	9	2017	JRNL0018	09/19/17
CCMIDWST	074	6901	60000620	KONICA M	148	9	2017	JRNL0018	09/19/17
CCMIDWST	074	6901	60000620	KONICA M	240	8	2017	JRNL0018	08/16/17
CCMIDWST	074	6901	60000620	KONICA M	158	8	2017	JRNL0018	08/16/17
CCMIDWST	074	6901	60000620	KONICA M	230	7	2017	JRNL0018	07/27/17
CCMIDWST	074	6901	60000620	KONICA M	148	7	2017	JRNL0018	07/27/17
CCMIDWST	074	6901	60000620	KONICA M	230	6	2017	JRNL0018	06/21/17
CCMIDWST	074	6901	60000620	KONICA M	148	6	2017	JRNL0018	06/21/17
CCMIDWST	074	6901	60000620	KONICA M	230	5	2017	JRNL0018	05/17/17
CCMIDWST	074	6901	60000620	KONICA M	148	5	2017	JRNL0018	05/17/17
CCMIDWST	074	6901	60000620	KONICA M	230	4	2017	JRNL0018	04/14/17
CCMIDWST	074	6901	60000620	KONICA M	148	4	2017	JRNL0018	04/14/17
CCMIDWST	074	6901	60000620	KONICA M	230	3	2017	JRNL0018	03/20/17
CCMIDWST	074	6901	60000620	KONICA M	148	3	2017	JRNL0018	03/20/17
CCMIDWST	074	6901	60000620	KONICA M	230	2	2017	JRNL0018	02/22/17
CCMIDWST	074	6901	60000620	KONICA M	148	2	2017	JRNL0018	02/22/17
CCMIDWST	074	6901	60000620	KONICA M	230	1	2017	JRNL0018	01/14/17
CCMIDWST	074	6901	60000620	KONICA M	148	1	2017	JRNL0018	01/14/17
CCMIDWST	074	6901	60000620	KONICA M	-	4	2017	JRNL0018	04/03/17
CCMIDWST	074	6901	60000620	KONICA M	-	4	2017	JRNL0018	04/03/17
CCMIDWST	074	6901	60000620	KONICA M	-	3	2017	JRNL0018	03/14/17
CCMIDWST	074	6901	60000620	KONICA M	-	3	2017	JRNL0018	03/14/17
CCMIDWST	074	6901	60000620	KONICA M	-	2	2017	JRNL0018	02/11/17
CCMIDWST	074	6901	60000620	KONICA M	-	2	2017	JRNL0018	02/11/17
CCMIDWST	074	6901	60000620	KONICA M	-	1	2017	JRNL0018	01/18/17
CCMIDWST	074	6901	60000620	KONICA M	-	1	2017	JRNL0018	01/18/17
CCMIDWST	074	8131	60000620	SPECIALIZ	177	9	2017	JRNL0018	09/30/17
CCMIDWST	074	8131	60000620	SPECIALIZ	305	8	2017	JRNL0018	08/31/17
CCMIDWST	074	8131	60000620	SPECIALIZ	305	7	2017	JRNL0018	07/28/17
CCMIDWST	074	8131	60000620	SPECIALIZ	295	6	2017	JRNL0018	06/30/17
CCMIDWST	074	8131	60000620	SPECIALIZ	150	5	2017	JRNL0018	05/31/17
CCMIDWST	074	8131	60000620	SPECIALIZ	128	3	2017	JRNL0018	03/31/17
CCMIDWST	074	8131	60000620	SPECIALIZ	436	2	2017	JRNL0018	02/28/17
CCMIDWST	074	8131	60000620	Rcl SMS in	300	11	2017	JRNL0019	11/30/17
CCMIDWST	074	8131	60000620	Rcl SMS Ir	250	2	2017	JRNL0018	02/28/17
CCMIDWST	074	8131	60000620	Rcl Equip I	(183)	4	2017	JRNL0018	04/30/17
CCMIDWST	074	8131	60000620	JOERNS H	116	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	171	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	378	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	30	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	136	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	30	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	136	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	53	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	JOERNS H	140	8	2017	JRNL0018	08/25/17
CCMIDWST	074	8131	60000620	JOERNS H	171	8	2017	JRNL0018	08/25/17
CCMIDWST	074	8131	60000620	JOERNS H	171	8	2017	JRNL0018	08/25/17
CCMIDWST	074	8131	60000620	JOERNS H	546	8	2017	JRNL0018	08/25/17
CCMIDWST	074	8131	60000620	JOERNS H	563	7	2017	JRNL0018	07/25/17
CCMIDWST	074	8131	60000620	JOERNS H	59	7	2017	JRNL0018	07/25/17
CCMIDWST	074	8131	60000620	JOERNS H	59	7	2017	JRNL0018	07/25/17
CCMIDWST	074	8131	60000620	JOERNS H	544	6	2017	JRNL0018	06/30/17
CCMIDWST	074	8131	60000620	JOERNS H	56	6	2017	JRNL0018	06/30/17
CCMIDWST	074	8131	60000620	JOERNS H	135	6	2017	JRNL0018	06/30/17
CCMIDWST	074	8131	60000620	JOERNS H	1,126	5	2017	JRNL0018	05/22/17
CCMIDWST	074	8131	60000620	JOERNS H	183	4	2017	JRNL0018	04/20/17
CCMIDWST	074	8131	60000620	JOERNS H	83	4	2017	JRNL0018	04/20/17
CCMIDWST	074	8131	60000620	ISAVE - JC	165	12	2017	JRNL0019	12/11/17
CCMIDWST	074	8131	60000620	ISAVE - JC	171	11	2017	JRNL0019	11/06/17
CCMIDWST	074	8131	60000620	ISAVE - JC	465	11	2017	JRNL0019	11/06/17
CCMIDWST	074	8131	60000620	ISAVE - JC	61	10	2017	JRNL0018	10/09/17
CCMIDWST	074	8131	60000620	ISAVE - JC	165	10	2017	JRNL0018	10/09/17
CCMIDWST	074	8131	60000620	CR-SMS C	(17)	2	2017	JRNL0018	02/28/17
CCMIDWST	074	8131	60000620	CR-SMS C	(30)	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	CR-SMS C	(18)	7	2017	JRNL0018	07/31/17
CCMIDWST	074	8131	60000620	CR-SMS C	(38)	6	2017	JRNL0018	06/30/17
CCMIDWST	074	8131	60000620	CR- Joerns	(92)	11	2017	JRNL0019	11/30/17
CCMIDWST	074	8131	60000620	CR- Joerns	(662)	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	CR- Joerns	(106)	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	Acc ISV-Jc	(61)	10	2017	JRNL0018	10/31/17
CCMIDWST	074	8131	60000620	Acc ISV-Jc	61	9	2017	JRNL0018	09/30/17
CCMIDWST	074	8131	60000620	Acc ISV-Jc	(165)	10	2017	JRNL0018	10/31/17
CCMIDWST	074	8131	60000620	Acc ISV-Jc	165	9	2017	JRNL0018	09/30/17
CCMIDWST	074	8131	60000620	Acc 12/17	171	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	Acc 11/17	(165)	12	2017	JRNL0019	12/31/17
CCMIDWST	074	8131	60000620	Acc 11/17	165	11	2017	JRNL0019	11/30/17
CCMIDWST	074	8131	60000620	Acc 10/17	(465)	11	2017	JRNL0019	11/30/17
CCMIDWST	074	8131	60000620	Acc 10/17	465	10	2017	JRNL0018	10/31/17
CCMIDWST	074	8131	60000620	Acc 10/17	(171)	11	2017	JRNL0019	11/30/17
CCMIDWST	074	8131	60000620	Acc 10/17	171	10	2017	JRNL0018	10/31/17
CCMIDWST	074	8200	60000620	ACCELER.	982	12	2017	JRNL0019	12/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	11	2017	JRNL0019	11/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	10	2017	JRNL0018	10/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	9	2017	JRNL0018	09/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	8	2017	JRNL0018	08/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	7	2017	JRNL0018	07/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	6	2017	JRNL0018	06/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	5	2017	JRNL0018	05/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	4	2017	JRNL0018	04/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	3	2017	JRNL0018	03/25/17
CCMIDWST	074	8200	60000620	ACCELER.	982	2	2017	JRNL0018	02/25/17
CCMIDWST	074	8200	60000620	ACCELER.	971	1	2017	JRNL0018	01/25/17
CCMIDWST	074	8200	60000620	ACCELER.	11	1	2017	JRNL0018	01/27/17

Total 33,655

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	0.00 hrs	$ 0	3953.00	$ 193,287	$ 0	3,953	$ 193,287	1
2	Licensed Speech and Language Development Therapist	V10A	0.00 hrs	0	1,610	58,434	0	1,610	58,434	2
3	Licensed Recreational Therapist	V10A	0.00 hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00 hrs	0	3,785	191,820	0	3,785	191,820	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	0.00 hrs	0	0	0	2,785		2,785	8
9	Pharmacy	V39	0.00 # of prescrpts	0	0	0	68,835		68,835	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00	0	0	0	8,782		8,782	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00	0	0	0	13,843		13,843	13
14	TOTAL			$	9,347	$ 443,541	$ 94,245	9,347	$ 537,786	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 Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (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	$ 1,000	$ 1,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 194,478)	146,771	146,771	3
4	Supply Inventory (priced at)	42,017	42,017	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,495	1,495	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	8,208	8,208	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 199,491	$ 199,491	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		595,949	14
15	Leasehold Improvements, at Historical Cost	761,019	761,019	15
16	Equipment, at Historical Cost	172,761	340,372	16
17	Accumulated Depreciation (book methods)	(543,522)	(676,990)	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): Cost Settlements	14,443	14,443	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 404,701	$ 1,034,793	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 604,192	$ 1,234,284	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,772	$ 1,772	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,994	63,994	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Intercompany	774,595	1,351,213	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 840,361	$ 1,416,979	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	QAF Fees, Legal Fees	58,760	58,760	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 58,760	$ 58,760	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 899,121	$ 1,475,739	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (294,929)	$ (241,455)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 604,192	$ 1,234,284	48

*(See instructions.)

Mid West SNF/RES

075-CC Virden, LLC (#074)

For the Twelve Months Ending December 31, 2017

Acct Number	Dept	Account	Description	***YTD***
075-0000-12	0000	12210000	BLDG & IMPV - FACILITY BUILDINGS	595,949.00
075-0000-12	0000	12410000	EQUIP - MAJOR MOVABLE	167,611.00
075-0000-12	0000	12710000	ACC DEPR - FACILITY BUILDINGS	(49,662.32)
075-0000-12	0000	12910000	ACC DEPR - MAJOR MOVABLE EQUIP	(83,805.58)
075-0000-20	0000	20800099	INTERCOMPANY	(576,618.00)
075-0000-24	0000	24400100	EQUITY - RETAINED EARNINGS	(53,474.10)
075-0000-29	0000	29990000	CURRENT YEAR PROFIT/LOSS	41,238.84
075-7100-70	7100	70009220	PROPERTY DEPR-BLDGS & IMPROVEMENTS	19,864.92
075-7100-70	7100	70009240	PROPERTY DEPR-MAJOR MOVABLE EQUIP	33,522.24
075-8000-40	8000	40003430	MISC. REV. RENT INCOME	(94,626.00)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 129,826	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 129,824	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(424,753)	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)**	$ (424,753)	17
	B. Transfers (Itemize):		
18	ILU net asset activity for the year	0	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (294,929)	24 *

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 3,900,959	1
2	Discounts and Allowances for all Levels	(1,208,813)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,692,146	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,517,431	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,517,431	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	72,868	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,931	19
20	Radiology and X-Ray	4,514	20
21	Other Medical Services	14,711	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 96,024	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	AL/IL		28
28a	Misc Revenue		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,305,613	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	615,877	31
32	Health Care	2,159,616	32
33	General Administration	1,410,180	33
	B. Capital Expense		
34	Ownership	269,820	34
	C. Ancillary Expense		
35	Special Cost Centers	94,245	35
36	Provider Participation Fee	180,628	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,730,366	40
41	**Income before Income Taxes (line 30 minus line 40)****	(424,753)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (424,753)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,657,957	44
45	Private Pay - Net Inpatient Revenue	1,085,618	45
46	Medicare - Net Inpatient Revenue	1,012,777	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	237,645	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,301,852)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,692,146	49

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

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

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

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

Facility Name & ID Number Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,328	1,328	$ 68,074	$ 51.26	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	9,002	9,993	326,957	32.72	3
4	Licensed Practical Nurses	13,638	13,638	266,174	19.52	4
5	CNAs & Orderlies	50,151	50,151	647,798	12.92	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,802	1,802	21,372	11.86	9
10	Activity Assistants	2,340	2,414	24,085	9.98	10
11	Social Service Workers	3,938	4,022	64,283	15.98	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,328	1,328	23,084	17.38	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	10,507	10,660	106,134	9.96	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,301	2,371	39,021	16.46	17
18	Housekeepers	7,572	7,699	72,731	9.45	18
19	Laundry	2,632	2,690	27,062	10.06	19
20	Administrator	1,765	1,765	38,554	21.84	20
21	Assistant Administrator	522	522	22,335	42.79	21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	4,347	4,435	103,606	23.36	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,478	1,492	30,540	20.47	31
32	Other Health Care(specify)	2,549	2,549	53,879	21.14	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	117,200	118,859	$ 1,935,689 *	$ 16.29	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	215	$ 10,554	V01-3	35
36	Medical Director	81	15,000	V09-3	36
37	Medical Records Consultant	8	240	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	98	2,986	V11-3	44
45	Social Service Consultant	227	19,739	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	628	$ 48,519		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Sunrise Skilled Nur & Rehab # 0051458 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Barnes	Administrator	0	$ 10,754
Keri Shatley	Administrator	0	35,758
Alicia Oakley	Asst Admin	0	14,377
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,889

B. Administrative - Other

Description	Amount
Management Fees - Covenant Care California, LLC	$ 215,121
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 215,121

C. Professional Services

Vendor/Payee	Type	Amount
Wescom Solutions Inc	Data Processing	$ 36,247
360 Healthcare Staffing	Admin Staffing	50,840
Ability Network	Data Processing	620
Verify	Data Processing	1,948
National Datacare Corp	Data Processing	1,760
Nova Voice & Data Systems	Telecommunications	4,213
Pinnacle Quality Insight	Customer Satisfaction	1,990
Smartlinx Solutions, LLC	Labor Management	3,972
Shred-It	Paper Shredding	1,163
Legal	See Attached	2,673
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 105,427

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,648
Unemployment Compensation Insurance	
FICA Taxes	189,707
Employee Health Insurance	131,720
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	359
Vision Insurance	(24)
Group Life & Disability	1,494
Other Employee Benefits	6,315
Employee Physical/X-Ray	2,210
TOTAL (agree to Schedule V, line 22, col.8)	$ 388,428

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	$ 1,990
Advertising: Employee Recruitment	12,766
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	2,262
Licenses & Permits	2,100
Publications/Manuals	
Allocated from Covenant Care California	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,118

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	104
Allocated from Covenant Care California	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 104

* Attach copy of IMRF notifications

**See instructions.

Company	Locn	Dept	Account	Journal_Desc	Amount	Month	Year	JournalNum	ApplyDate	Purpose	check	invoice
CCMIDWS	074	6901	60000470	Acr Sandb	10,341	2	2017	JRNL0018	02/28/17	reclassified		
CCMIDWS	074	6901	60000470	Acr Sandb	7,485	3	2017	JRNL0018	03/31/17	reclassified		
CCMIDWS	074	6901	60000470	Acr reverse	(10,341)	3	2017	JRNL0018	03/31/17	reclassified		
CCMIDWS	074	6901	60000470	Acr reverse	(7,485)	3	2017	JRNL0018	03/31/17	reclassified		
CCMIDWS	074	6901	60000470	Acr Sandb	(10,341)	3	2017	JRNL0018	03/31/17	reclassified		
CCMIDWS	074	6901	60000470	Acr Sandb	10,341	3	2017	JRNL0018	03/31/17	reclassified		
CCMIDWS	074	6901	60000470	Acr Sandb	(7,485)	4	2017	JRNL0018	04/30/17	reclassified		
CCMIDWS	074	6901	60000470	Acr reverse	10,341	4	2017	JRNL0018	04/30/17	reclassified		
CCMIDWS	074	6901	60000470	Acr reverse	7,485	4	2017	JRNL0018	04/30/17	reclassified		
CCMIDWS	074	6901	60000470	Acr Sandb	(10,341)	4	2017	JRNL0018	04/30/17	reclassified		
CCMIDWS	074	6901	60000470	SANDBER	10,341	5	2017	JRNL0018	05/31/17	reclassified		
CCMIDWS	074	6901	60000470	Rcl Sandb	(10,341)	5	2017	JRNL0018	05/31/17	reclassified		
CCMIDWS	074	6901	60000470	SANDBER	7,485	5	2017	JRNL0018	05/31/17	reclassified		
CCMIDWS	074	6901	60000470	Rcl Sandb	(7,485)	5	2017	JRNL0018	05/31/17	reclassified		
CCMIDWS	074	6901	60000470	Acr Sandb	212	5	2017	JRNL0018	05/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,236	5	2017	JRNL0018	05/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	212	6	2017	JRNL0018	06/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(212)	6	2017	JRNL0018	06/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,236	6	2017	JRNL0018	06/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(1,236)	6	2017	JRNL0018	06/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	212	7	2017	JRNL0018	07/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(212)	7	2017	JRNL0018	07/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,236	7	2017	JRNL0018	07/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(1,236)	7	2017	JRNL0018	07/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	184	8	2017	JRNL0018	08/31/17	Resident matter		
CCMIDWS	074	6901	60000470	Acr Sandb	212	8	2017	JRNL0018	08/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(212)	8	2017	JRNL0018	08/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,236	8	2017	JRNL0018	08/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(1,236)	8	2017	JRNL0018	08/31/17			
CCMIDWS	074	6901	60000470	SANDBER	718	9	2017	JRNL0018	09/19/17	Employee matter		
CCMIDWS	074	6901	60000470	Acr Sandb	184	9	2017	JRNL0018	09/30/17	Resident matter		
CCMIDWS	074	6901	60000470	Acr Sandb	(184)	9	2017	JRNL0018	09/30/17	Resident matter		
CCMIDWS	074	6901	60000470	Acr Sandb	212	9	2017	JRNL0018	09/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(212)	9	2017	JRNL0018	09/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,236	9	2017	JRNL0018	09/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(1,236)	9	2017	JRNL0018	09/30/17			
CCMIDWS	074	6901	60000470	SANDBER	184	10	2017	JRNL0018	10/31/17	Resident matter		
CCMIDWS	074	6901	60000470	Acr Sandb	(184)	10	2017	JRNL0018	10/31/17	Resident matter		
CCMIDWS	074	6901	60000470	Acr Sandb	212	10	2017	JRNL0018	10/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(212)	10	2017	JRNL0018	10/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,236	10	2017	JRNL0018	10/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(1,236)	10	2017	JRNL0018	10/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	212	11	2017	JRNL0019	11/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(212)	11	2017	JRNL0019	11/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,236	11	2017	JRNL0019	11/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(1,236)	11	2017	JRNL0019	11/30/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,081	11	2017	JRNL0019	11/30/17	Survey Matter		
CCMIDWS	074	6901	60000470	Acr Hanso	690	12	2017	JRNL0019	12/31/17	Survey Matter		
CCMIDWS	074	6901	60000470	Acr Sandb	(212)	12	2017	JRNL0019	12/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	(1,236)	12	2017	JRNL0019	12/31/17			
CCMIDWS	074	6901	60000470	Acr Sandb	1,081	12	2017	JRNL0019	12/31/17	Survey Matter		
CCMIDWS	074	6901	60000470	Acr Sandb	(1,081)	12	2017	JRNL0019	12/31/17	Survey Matter		

Total					2,673

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. **AHCA,IHCA $6,534**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **17,819** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES ___ **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ___ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **180,628**
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? **N/A** Indicate the amount. $ **N/A**

(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? **100% Ln 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees