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: 0011643

Facility Name: Sunset Home

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

County: Adams

Telephone Number: (217) 223-2636 **Fax #** (217) 223-6750

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	501C (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 10/01/16 to 09/30/17 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)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 10/01/16 Ending: 09/30/17

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 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	66,430	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	66,430	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			5,741	5,741	8
9	SNF/PED					9
10	ICF	29,072	16,374	68	45,514	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,072	16,374	5,809	51,255	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.16%

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)
Individual 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 5,030

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: 9/30/17 Fiscal Year: 9/30/17

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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	518,749	39,336	16,750	574,835		574,835		574,835			1
2	Food Purchase		402,253		402,253		402,253	(22,455)	379,798			2
3	Housekeeping	253,982	28,303	5,549	287,834		287,834		287,834			3
4	Laundry	51,852	4,858	165,544	222,254		222,254		222,254			4
5	Heat and Other Utilities			377,083	377,083		377,083	(30,750)	346,333			5
6	Maintenance	124,891	37,380	114,244	276,515		276,515	(6,359)	270,156			6
7	Other (specify):*											7
8	TOTAL General Services	949,474	512,130	679,170	2,140,774		2,140,774	(59,564)	2,081,210			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	4,160,898	243,042	11,580	4,415,520		4,415,520		4,415,520			10
10a	Therapy											10a
11	Activities	131,914	10,968		142,882		142,882	(148)	142,734			11
12	Social Services	174,413	634	3,491	178,538		178,538		178,538			12
13	CNA Training											13
14	Program Transportation			376	376		376		376			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,467,225	254,644	21,447	4,743,316		4,743,316	(148)	4,743,168			16
	C. General Administration											
17	Administrative	105,289			105,289		105,289		105,289			17
18	Directors Fees											18
19	Professional Services			222,996	222,996		222,996	(19,977)	203,019			19
20	Dues, Fees, Subscriptions & Promotions			216,146	216,146		216,146	(93,596)	122,550			20
21	Clerical & General Office Expenses	336,139	23,421	418,106	777,666		777,666	(346,444)	431,222			21
22	Employee Benefits & Payroll Taxes			1,722,743	1,722,743		1,722,743	(13,531)	1,709,212			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,351	4,351		4,351		4,351			24
25	Other Admin. Staff Transportation			9,193	9,193		9,193	(547)	8,646			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	441,428	23,421	2,593,535	3,058,384		3,058,384	(474,094)	2,584,290			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,858,127	790,195	3,294,152	9,942,474		9,942,474	(533,806)	9,408,668			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: 10/01/16 Ending: 09/30/17

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			621,725	621,725		621,725	(91,092)	530,633			30
31	Amortization of Pre-Op. & Org.			6,549	6,549		6,549	(6,549)	0			31
32	Interest			129,251	129,251		129,251	(44,736)	84,515			32
33	Real Estate Taxes			937	937		937		937			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			758,462	758,462		758,462	(142,377)	616,085			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		229,309	558,291	787,600		787,600		787,600			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			18,170	18,170		18,170	(567)	17,603			41
42	Provider Participation Fee			374,034	374,034		374,034		374,034			42
43	Other (specify):*	54,607		620,799	675,406		675,406	(675,406)	0			43
44	**TOTAL Special Cost Centers**	54,607	229,309	1,571,294	1,855,210		1,855,210	(675,973)	1,179,237			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,912,734	1,019,504	5,623,908	12,556,146		12,556,146	(1,352,156)	11,203,990			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: 10/01/16 Ending: 09/30/17

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 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	(17,914)	02		4
5	Telephone, TV & Radio in Resident Rooms	(30,750)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	75,318	30		9
10	Interest and Other Investment Income	(44,736)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(638)	21		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	(328,372)	21		24
25	Fund Raising, Advertising and Promotional	(73,729)	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	(931,335)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,352,156)		$	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))**	$ (1,352,156)		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: 10/01/16

Ending: 09/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cost of Handi Rack Sales	$ (4,541)	02	1
2	Cost of Ceramics	(148)	11	2
3	Promotional Expenses	(19,867)	20	3
4	Villa Expenses	(113,428)	43	4
5	Apartment Expenses	(507,371)	43	5
6	Community Outreach	(1,395)	21	6
7	Officer/Director/Board	(696)	21	7
8	Dir/Officers' Liability Insurance	(13,531)	22	8
9	Amortization of Bond Expense	(6,549)	31	9
10	Marketing Director	(54,607)	43	10
11	Marketing Travel	(547)	25	11
12	Processing Fee	(3,100)	21	12
13	Sunset Clothing Sales	(567)	41	13
14	Beauty Shop Rental	(1,785)	21	14
15	Meeting Rooms Rental	(425)	21	15
16	Miscellaneous Income	(10,033)	21	16
17	Non Care Depreciation	(166,410)	30	17
18	Non Allowable Legal	(19,977)	19	18
19	Capitalized R&M	(6,359)	06	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**	(931,335)		49

Sunset Home

ID# 0011643

Report Period Beginning: 10/01/16

Ending: 09/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunset Home # 0011643 **Report Period Beginning:** 10/01/16 **Ending:** 09/30/17

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													1
2	Food Purchase	(22,455)											(22,455)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(30,750)											(30,750)	5
6	Maintenance	(6,359)											(6,359)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(59,564)											(59,564)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(148)											(148)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(148)											(148)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(19,977)											(19,977)	19
20	Fees, Subscriptions & Promotions	(93,596)											(93,596)	20
21	Clerical & General Office Expenses	(346,444)											(346,444)	21
22	Employee Benefits & Payroll Taxes	(13,531)											(13,531)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(547)											(547)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(474,094)											(474,094)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(533,806)											(533,806)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Sunset Home** **#** **0011643** **Report Period Beginning:** **10/01/16** **Ending:** **09/30/17**

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(91,092)											(91,092)	30
31	Amortization of Pre-Op. & Org.	(6,549)											(6,549)	31
32	Interest	(44,736)											(44,736)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(142,377)											(142,377)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(567)											(567)	41
42	Provider Participation Fee													42
43	Other (specify):*	(675,406)											(675,406)	43
44	**TOTAL Special Cost Centers**	(675,973)											(675,973)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,352,156)											(1,352,156)	45

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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
None		None		None		

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: 10/01/16 Ending: 09/30/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ YES ☐ NO

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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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ YES ☐ NO

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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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$	$ *	39

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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								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: 10/01/16 Ending: 09/30/17

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								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: 10/01/16 Ending: 09/30/17

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 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: 10/01/16 Ending: 09/30/17

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 Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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 ☐

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: 10/01/16 Ending: 09/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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Street Address
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	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: 10/01/16 Ending: 09/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
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	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
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12										12
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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: 10/01/16 Ending: 09/30/17

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
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	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
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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: 10/01/16 Ending: 09/30/17

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 ☐

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

Name of Related Organization
Street Address
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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
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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: 10/01/16 Ending: 09/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
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Phone Number ( )
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	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
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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: 10/01/16 Ending: 09/30/17

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 ☐

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
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9										9
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19										19
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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 ☐

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
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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: 10/01/16 Ending: 09/30/17

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 ☐

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
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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: 10/01/16 Ending: 09/30/17

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Peoples Prosperity Bank		X	Renovation		12/1/13	$ 6,000,000	$ 5,255,960	12/27/2033	0.0254	$ 85,001	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Peoples Prosperity Bank		X	Working Capital				989,250		0.0350	38,260	6
7	Wells Fargo		X	Note Payable				124,116			5,990	7
8												8
9	TOTAL Facility Related						$ 6,000,000	$ 6,369,326			$ 129,251	9
	B. Non-Facility Related*											
10	Investment Income		X								(44,736)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (44,736)	14
15	TOTALS (line 9+line14)						$ 6,000,000	$ 6,369,326			$ 84,515	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:** 10/01/16 **Ending:** 09/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 25,985	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.)		$ 937	2
3. Under or (over) accrual (line 2 minus line 1).		$ (25,048)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 25,985	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.		$ 937	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	903	8
	2013	915	9
	2014	900	10
	2015	932	11
	2016	937	12

Beginning accrual adjusted to include apartment real estate tax accrual

	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 Sunset Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.	23-2-0917-000-00	Vacant Lot	$ 111.86	$ 111.86
2.	23-2-0926-000-00	Vacant Lot	$ 218.94	$ 218.94
3.	23-2-0971-000-00	Vacant Lot	$ 158.24	$ 158.24
4.	23-2-0972-000-00	Vacant Lot	$ 52.52	$ 52.52
5.	23-2-0973-000-00	Vacant Lot	$ 52.52	$ 52.52
6.	23-2-0974-000-00	Vacant Lot	$ 89.36	$ 89.36
7.	23-2-0975-000-00	Vacant Lot	$ 155.52	$ 155.52
8.	23-2-0979-000-00	Vacant Lot	$ 98.22	$ 98.22
9.			$	$
10.			$	$
		TOTALS	$ 937.18	$ 937.18

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunset Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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: 10/01/16 Ending: 09/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior Brick Frame Steel-Fireproof 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 Apartments 16 2 Bedroom Units 16,000 Sq Ft

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 Additional	15,000	1996-1997	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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	34		1958	1958	$ 354,000	$	50	$	$	$ 354,000	4
5	51		1971	1971	1,218,562	24,371	50	24,371	0	1,121,048	5
6	49		1972	1972	472,577	9,452	50	9,452	(0)	432,417	6
7	5		1987	1987	68,497		50			68,497	7
8	43		2000	2000	2,500,281	50,006	50	50,006	(0)	1,133,463	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			304,188	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			723,324	14
15	Various			1979	34,002		20			34,002	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			389,702	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			306,267	30
31	Various			1996	35,920		20			35,920	31
32	Various			1997	396,712		20			396,712	32
33	Various			1998	280,005		20	14,000	14,000	280,005	33
34	Various			1999	54,659		20	2,733	2,733	51,926	34
35	Various			2000	320,831		20	16,042	16,042	288,748	35
36	Various			2001	66,692		20	3,335	3,335	56,688	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: 10/01/16 Ending: 09/30/17

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	Various	2002	$ 130,594	$	20	$ 6,530	$ 6,530	$ 104,475	37
38	Various	2003	113,479		20	5,674	5,674	85,109	38
39	Various	2004	161,608		20	8,080	8,080	113,126	39
40	Various	2005	51,320		20	2,566	2,566	33,358	40
41	Various	2006	99,854		20	4,993	4,993	59,912	41
42	Various	2007	2,851,356		20	142,568	142,568	1,568,246	42
43	Various	2008	24,923		20	1,246	1,246	12,462	43
44	Various	2009	40,403		20	2,020	2,020	18,181	44
45	Various	2010	15,535		20	777	777	6,214	45
46	Various	2011	44,611		20	2,231	2,231	15,614	46
47	Various	2012	359,755		20	17,988	17,988	107,926	47
48	Various	2013	161,613		20	8,081	8,081	40,403	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)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			371,485			(371,485)		69
70	TOTAL (lines 4 thru 69)		$ 13,383,636	$ 455,314		$ 322,690	$ (132,624)	$ 9,944,300	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: 10/01/16 Ending: 09/30/17

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		$ 13,383,636	$ 455,314		$ 322,690	$ (132,624)	$ 9,944,300	1
2	Elevator - City View	2014	29,450		20	1,473	1,473	5,890	2
3	Code Alert System	2014	32,320		20	1,616	1,616	6,464	3
4	New Boiler / South	2014	35,082		20	1,754	1,754	7,016	4
5	Replace North And South Area Roofs (City,River, And Southern V	2014	152,000		20	7,600	7,600	30,400	5
6	2Nd Floor Dr Remodel:Floors,Painting,Hvac Plumbing,Electrical,	2014	325,127		20	16,256	16,256	65,025	6
7	Lighting - 2Nd Floor	2014	3,536		20	177	177	707	7
8	17 Overbed Lights	2014	3,698		20	185	185	740	8
9	Panel For Chiller	2014	3,463		20	173	173	693	9
10	2Nd Fl Bathrooms Outside Res Dr - Install Toilets, Valves, Sinks	2014	14,521		20	726	726	2,904	10
11	Replace Boiler #2	2014	54,000		20	2,700	2,700	10,800	11
12	Replace Compressor	2014	26,801		20	1,340	1,340	5,360	12
13	Repair Diesel Tank	2014	2,586		20	129	129	517	13
14	Administration Office Carpet	2014	4,768		20	238	238	954	14
15	Shower Room 3Rd Fl Floors & Walls	2015	7,813		20	391	391	1,172	15
16	Rooftop Paint	2015	2,650		20	133	133	398	16
17	Elevator Modernization, Louver Hood, Conduit Wiring	2015	114,198		20	5,710	5,710	17,130	17
18	Beauty Shop Remodel 1Rv - Plumbing, Walls, Sinks, Wiring	2015	3,463		20	173	173	519	18
19	Wash Room Flooring & Patch Hallway	2015	3,485		20	174	174	523	19
20	Haven Shower Repair Water Damage	2015	2,960		20	148	148	444	20
21	Laundry Room Flooring	2015	15,810		20	791	791	2,372	21
22	Repair Condenser Leak	2015	2,790		20	140	140	419	22
23	4Th Fl Short Term Rehab Center	2016	1,316,045		20	65,802	65,802	131,605	23
24	Laundry Rm- Hallway & Floor	2016	16,567		20	828	828	1,657	24
25	Fire Door In Haven- East Hallway	2016	2,950		20	148	148	295	25
26	Power Running From Garage To Lawn	2016	4,140		20	207	207	414	26
27	Chapel Remodel- Flooring, Lighting, Painting	2016	35,018		20	1,751	1,751	3,502	27
28	Cafeteria/Sw Corner Roof Repair	2016	10,300		20	515	515	1,030	28
29	Kitchen Drain Grease Trap	2016	3,475		20	174	174	348	29
30	3Cv Remodel- Lighting, Ceiling, Wiring Phone/Internet, Paint	2016	178,939		20	8,947	8,947	17,894	30
31	Leaf Relief Gutter Protection	2016	2,700		20	135	135	270	31
32	Courtyard Landscape Renovation	2016	4,872		20	244	244	487	32
33	Versa Lock Wall On 4Th Street	2016	5,250		20	263	263	525	33
34	TOTAL (lines 1 thru 33)		$ 15,804,411	$ 455,314		$ 443,729	$ (11,585)	$ 10,262,771	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: 10/01/16 Ending: 09/30/17

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 12B, Carried Forward		$ 15,804,411	$ 455,314		$ 443,729	$ (11,585)	$ 10,262,771	1
2	4Cv Therapy Room Data Cabling/Outlets	2016	3,322		20	166	166	166	2
3	2Cv Dual Data Installation & Wiring	2016	8,439		20	422	422	422	3
4	Installed 10 Electrical Outlets On 5 Columns In Alzheimers Wing	2017	4,874		20	244	244	244	4
5	1500 Gallon Fuel Tank	2017	8,856		20	443	443	443	5
6	3Cv Ceiling Wiring & Lighting	2017	3,027		20	151	151	151	6
7	Centrifugal Pump Repair	2017	3,509		20	175	175	3,509	7
8	Rebuild Industrial Kitchen Ventilation Fan	2017	2,850		20	142	142	142	8
9									9
10									10
11									11
12									12
13									13
14									14
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,839,287	$ 455,314		$ 445,473	$ (9,841)	$ 10,267,849	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: 10/01/16 Ending: 09/30/17

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 12D, Carried Forward		$ 15,839,287	$ 455,314		$ 445,473	$ (9,841)	$ 10,267,849	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,839,287	$ 455,314		$ 445,473	$ (9,841)	$ 10,267,849	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: 10/01/16 Ending: 09/30/17

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 12C, Carried Forward		$ 15,839,287	$ 455,314		$ 445,473	$ (9,841)	$ 10,267,849	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,839,287	$ 455,314		$ 445,473	$ (9,841)	$ 10,267,849	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: 10/01/16 Ending: 09/30/17

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 10/01/16 Ending: 09/30/17

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 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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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)		$	$		$	$	$	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: 10/01/16 Ending: 09/30/17

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 10/01/16 Ending: 09/30/17

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 12H, Carried Forward		$	$		$	$	$	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 10/01/16 Ending: 09/30/17

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	$ 696,781	$	$ 69,678	$ 69,678	10	$ 319,817	71
72	Current Year Purchases	8,801		880	880	10	880	72
73	Fully Depreciated Assets	928,311				10	928,311	73
74								74
75	TOTALS	$ 1,633,893	$	$ 70,558	$ 70,558		$ 1,249,008	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	$ 22,263	76
77		2014 Ford F250 - Silver	2014	26,199		5,240	5,240	5	18,340	77
78		Auto Assets	1900	137,461		3,000	3,000	5	130,737	78
79										79
80	TOTALS			$ 195,463	$	$ 14,601	$ 14,601		$ 171,340	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)	$ 17,857,350	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 455,314	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 530,632	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 75,318	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,688,197	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	Villa Fixed Assets - 2017	$ 1,933,750	$ 61,058	$ 1,266,811	86
87	Sunset Apartments - 2017	3,291,640	105,352	1,212,398	87
88					88
89					89
90					90
91	TOTALS	$ 5,225,390	$ 166,410	$ 2,479,209	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Smoke Barriers	$ 13,022	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 Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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:				$			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.	/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: $ ____ 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: 10/01/16 Ending: 09/30/17

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.

Facility Name & ID Number Sunset Home

STATE OF ILLINOIS
0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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	$		$ 216,192	$		$ 216,192	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			47,709			47,709	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			288,839			288,839	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				229,309		229,309	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					5,551			5,551	13
14	TOTAL			$		$ 558,291	$ 229,309		$ 787,600	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:** 10/01/16 **Ending:** 09/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/17 (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	$ 119,287	$	1
2	Cash-Patient Deposits	16,709		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,270,731		3
4	Supply Inventory (priced at)	41,364		4
5	Short-Term Investments	956,892		5
6	Prepaid Insurance	28,053		6
7	Other Prepaid Expenses	5,134		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	816,767		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,254,937	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,273,033		12
13	Land	2,038,736		13
14	Buildings, at Historical Cost	9,254,627		14
15	Leasehold Improvements, at Historical Cost	8,970,637		15
16	Equipment, at Historical Cost	4,634,602		16
17	Accumulated Depreciation (book methods)	(13,697,954)		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 Schedule	176,376		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,650,057	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,904,994	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 924,669	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,709		28
29	Short-Term Notes Payable	989,250		29
30	Accrued Salaries Payable	378,586		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,915		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,985		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)**	$ 2,352,114	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,380,076		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,380,076	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,732,190	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,172,804	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,904,994	$	48

***(See instructions.)**

Facility Name & ID Number Sunset Home # 0011643 **Report Period Beginning:** 10/01/16 **Ending:** 09/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,297,997	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)**	$ 11,297,995	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,125,191)	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)**	$ (1,125,191)	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)**	$ 10,172,804	24 *

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

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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	$ 11,387,817	1
2	Discounts and Allowances for all Levels	(3,157,039)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,230,778	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,476,121	6
7	Oxygen	33,405	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,509,526	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	17,914	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	212,302	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,397	19
20	Radiology and X-Ray	1,344	20
21	Other Medical Services	10,740	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 282,697	23
	D. Non-Operating Revenue		
24	Contributions	265,097	24
25	Interest and Other Investment Income***	44,736	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 309,833	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,098,121	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,098,121	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,430,955	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,140,774	31
32	Health Care	4,743,316	32
33	General Administration	3,058,384	33
	B. Capital Expense		
34	Ownership	758,462	34
	C. Ancillary Expense		
35	Special Cost Centers	1,481,176	35
36	Provider Participation Fee	374,034	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,556,146	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,125,191)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,125,191)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,084,507	44
45	Private Pay - Net Inpatient Revenue	3,925,195	45
46	Medicare - Net Inpatient Revenue	1,127,867	46
47	Other-(specify) Managed Care/Contractual	93,209	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,230,778	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.**

Facility Name & ID Number Sunset Home # 0011643 Report Period Beginning: 10/01/16 Ending: 09/30/17

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	2,080	2,080	$ 81,236	$ 39.06	1
2	Assistant Director of Nursing	2,080	2,080	60,931	29.29	2
3	Registered Nurses	39,410	41,668	1,022,048	24.53	3
4	Licensed Practical Nurses	39,899	42,636	912,387	21.40	4
5	CNAs & Orderlies	143,601	154,396	2,009,125	13.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,203	3,295	51,079	15.50	9
10	Activity Assistants	8,489	9,035	80,835	8.95	10
11	Social Service Workers	9,639	10,092	150,198	14.88	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	51,642	24.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	41,859	44,562	467,107	10.48	15
16	Dishwashers					16
17	Maintenance Workers	8,814	9,322	124,891	13.40	17
18	Housekeepers	24,093	26,087	253,982	9.74	18
19	Laundry	3,964	4,343	51,852	11.94	19
20	Administrator	2,080	2,080	105,289	50.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,532	18,649	336,139	18.02	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	2,080	2,080	43,096	20.72	31
32	Other Health Care(specify)					32
33	Other(specify)	5,515	5,787	110,897	19.16	33
34	TOTAL (lines 1 - 33)	356,418	380,272	$ 5,912,734 *	$ 15.55	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	$ 16,750	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	Monthly	2,671	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,909	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,491	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,821		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: 10/01/16 Ending: 09/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn St. Clair Davis	Administrator	0	$ 105,289
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 105,289

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
ADP, Inc.	Payroll Services	$ 48,675
PointClickCare	E.H.R. Software	13,803
Ability Network, Inc.	Data Processing	5,296
Providigm, LLC	HC Quality Mgmt Solutions	3,060
FGMK, LLC	Accounting	29,910
Gray Hunter Stenn LLP	Accounting	31,875
Marcum LLP	Accounting	1,611
See Attached	Legal Fees	88,767
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 222,997

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 124,279
Unemployment Compensation Insurance	23,371
FICA Taxes	429,159
Employee Health Insurance	908,422
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	5,280
Pension	114,197
Perks/Gifts	26,852
Physicals/Drug Tests	271
Liability Insurance	77,381
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,709,212

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	$ 1,100
Advertising: Employee Recruitment	19,856
Health Care Worker Background Check	
(Indicate # of checks performed 370)	3,700
Patient Background Checks	
Dues & Subscriptions	97,893
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 122,549

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,351
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,351

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sunset Home # 0011643 **Report Period Beginning:** 10/01/16 **Ending:** 09/30/17

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 $12,012 ; AANAC $119**

(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. $ **36,527** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **374,034**
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. $ **17,914**

(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 14**
d. Have vehicle usage logs been maintained? **Yes**
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 LLP**

(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