

		FOR BHF USE					

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**2020**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2020)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0055905</u></p> <p><b>Facility Name:</b> <u>SUNRISE SKILLED NUR REHAB</u></p> <p><b>Address:</b> <u>333 S WRIGHTSMAN ST</u> <u>VIRDEN</u> <u>62690</u>        Number City Zip Code</p> <p><b>County:</b> <u>MACOUPIN</u></p> <p><b>Telephone Number:</b> <u>217-965-4715</u> <b>Fax #</b> <u>217-965-5530</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/1/2019</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1473 755 1661 950">Officer or Administrator of Provider</td> <td data-bbox="1661 755 2553 950">(Signed) _____ <u>5/28/2021</u> (Date) (Type or Print Name) <u>Shully Lichtman</u> (Title) <u>Manager</u></td> </tr> <tr> <td data-bbox="1473 950 1661 1242">Paid Preparer</td> <td data-bbox="1661 950 2553 1242">(Signed) _____ <u>5/27/2021</u> (Date) (Print Name and Title) <u>AARON MAUER</u> <u>President</u> (Firm Name &amp; Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u> (Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ <u>5/28/2021</u> (Date) (Type or Print Name) <u>Shully Lichtman</u> (Title) <u>Manager</u>	Paid Preparer	(Signed) _____ <u>5/27/2021</u> (Date) (Print Name and Title) <u>AARON MAUER</u> <u>President</u> (Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u> (Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>
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<p>In the event there are further questions about this report, please contact:  <b>Name:</b> <u>AARON MAUER</u> <b>Telephone Number:</b> <u>773-747-4506</u>  <b>Email Address:</b> _____</p>	<p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>																												

Facility Name & ID Number SUNRISE SKILLED NUR REHAB

# 0055905 Report Period Beginning: 01/01/20 Ending: 12/31/20

**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	Skilled (SNF)	41	15,006	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,960	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,636	2,007	4,275	12,918	8
9	SNF/PED					9
10	ICF	9,710	2,938	929	13,577	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,346	4,945	5,204	26,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.67%

D. How many bed reserve days during this year were paid by the Department? NONE (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES  NO

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

I. On what date did you start providing long term care at this location? Date started 9/1/2019

J. Was the facility purchased or leased after January 1, 1978? YES  Date 9/1/2019 NO

K. Was the facility certified for Medicare during the reporting year? YES  NO  If YES, enter number of beds certified 41 and days of care provided 3,640

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number **SUNRISE SKILLED NUR REHAB** # **0055905** Report Period Beginning: **01/01/20** Ending: **12/31/20**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	200,303	14,627	1,232	216,162		216,162	14,336	230,498		1
2	Food Purchase		166,669		166,669		166,669		166,669		2
3	Housekeeping	118,033	17,573		135,606		135,606		135,606		3
4	Laundry		7,131		7,131		7,131		7,131		4
5	Heat and Other Utilities			152,527	152,527		152,527		152,527		5
6	Maintenance	64,361	43,384	34,502	142,247		142,247	5,115	147,362		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>382,697</b>	<b>249,384</b>	<b>188,261</b>	<b>820,342</b>		<b>820,342</b>	<b>19,450</b>	<b>839,792</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,694,247	190,848	246,448	2,131,543		2,131,543	36,396	2,167,939		10
10a	Therapy			594,252	594,252		594,252		594,252		10a
11	Activities	53,996	9,834		63,830		63,830		63,830		11
12	Social Services	51,600		9,703	61,303		61,303		61,303		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,799,843</b>	<b>200,682</b>	<b>871,403</b>	<b>2,871,928</b>		<b>2,871,928</b>	<b>36,396</b>	<b>2,908,324</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	84,338			84,338		84,338	96,406	180,744		17
18	Directors Fees										18
19	Professional Services			374,393	374,393		374,393	(333,402)	40,991		19
20	Dues, Fees, Subscriptions & Promotions			18,751	18,751		18,751		18,751		20
21	Clerical & General Office Expenses	98,165	30,249	442,945	571,359		571,359	(248,639)	322,720		21
22	Employee Benefits & Payroll Taxes			502,455	502,455		502,455	23,336	525,791		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,514	3,514		3,514		3,514		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			123,505	123,505		123,505		123,505		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>182,503</b>	<b>30,249</b>	<b>1,465,563</b>	<b>1,678,315</b>		<b>1,678,315</b>	<b>(462,300)</b>	<b>1,216,015</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,365,043</b>	<b>480,315</b>	<b>2,525,227</b>	<b>5,370,585</b>		<b>5,370,585</b>	<b>(406,453)</b>	<b>4,964,132</b>		<b>29</b>

\*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 &amp; ID Number

SUNRISE SKILLED NUR REHAB

#0055905

Report Period Beginning:

01/01/20

Ending:

12/31/20

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			6,238	6,238		6,238	46,654	52,892			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,858	19,858		19,858	103,938	123,796			32
33	Real Estate Taxes			31,439	31,439		31,439	469	31,908			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			357,535	357,535		357,535	(148,939)	208,596			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			21,168	21,168		21,168		21,168			38
39	Ancillary Service Centers		106,109		106,109		106,109		106,109			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			162,607	162,607		162,607		162,607			42
43	Other (specify):* <b>Bad Debt</b>			64,134	64,134		64,134	(64,134)				43
44	<b>TOTAL Special Cost Centers</b>		106,109	247,909	354,018		354,018	(64,134)	289,884			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,365,043	586,424	3,130,671	6,082,138		6,082,138	(619,526)	5,462,612			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(12,064)	30		9
10	Interest and Other Investment Income	(3,937)	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	(64,134)	43		24
25	Fund Raising, Advertising and Promotional	(54,972)	21		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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (135,107)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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	(484,419)	Various	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (484,419)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (619,526)		37

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SUNRISE SKILLED NUR REHAB

ID# 0055905

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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			13
14			14
15			15
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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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNRISE SKILLED NUR REHAB

# 0055905

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	14,336	0	0	0	0	0	0	0	0	0	14,336	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	5,115	0	0	0	0	0	0	0	0	0	5,115	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	19,450	0	0	0	0	0	0	0	0	0	19,450	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	36,396	0	0	0	0	0	0	0	0	0	36,396	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	36,396	0	0	0	0	0	0	0	0	0	36,396	16
	<b>C. General Administration</b>													
17	Administrative	0	96,406	0	0	0	0	0	0	0	0	0	96,406	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,428	(334,830)	0	0	0	0	0	0	0	0	(333,402)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(54,972)	(193,667)	0	0	0	0	0	0	0	0	0	(248,639)	21
22	Employee Benefits & Payroll Taxes	0	23,336	0	0	0	0	0	0	0	0	0	23,336	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(54,972)	(72,497)	(334,830)	0	0	0	0	0	0	0	0	(462,300)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(54,972)	(16,651)	(334,830)	0	0	0	0	0	0	0	0	(406,453)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNRISE SKILLED NUR REHAB# 0055905

Report Period Beginning:

01/01/20

Ending:

12/31/20

## 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	(12,064)	58,718	0	0	0	0	0	0	0	0	0	46,654	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,937)	107,875	0	0	0	0	0	0	0	0	0	103,938	32
33	Real Estate Taxes	0	469	0	0	0	0	0	0	0	0	0	469	33
34	Rent-Facility & Grounds	0	(300,000)	0	0	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(16,001)</b>	<b>(132,938)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(148,939)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(64,134)	0	0	0	0	0	0	0	0	0	0	(64,134)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(64,134)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(64,134)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(135,107)</b>	<b>(149,589)</b>	<b>(334,830)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(619,526)</b>	<b>45</b>



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
CREST ILLINOIS HOLDCO LLC	100	Cedar Ridge	Lebanon	Crest Consulting	Chicago	Consulting Co
		Hallmark of Perkin	Perkin	Crest Realty LLC	Chicago	Real Estate
		Hallmark of Carnville	Carnville	Crest Manangement	Chicago	Management Co
		Highland Care	Highland			
		Hilltop Care	Charlestown			
		Jacksonville	Jacksonville			
		Paris Health	Paris			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Management Fee	\$ 207,689	Crest Consulting		\$	(207,689)	1
2	V	1 Dietary		Crest Consulting		14,336	14,336	2
3	V	6 Maintenance		Crest Consulting		5,115	5,115	3
4	V	10 Nursing and Medical Records		Crest Consulting		36,396	36,396	4
5	V	17 Administrative		Crest Consulting		96,406	96,406	5
6	V	21 Clerical & General Office Expenses		Crest Consulting		14,022	14,022	6
7	V	22 Employee Benefits & Payroll Taxes		Crest Consulting		23,336	23,336	7
8	V	19 Professional Services		Crest Realty LLC		1,428	1,428	8
9	V	30 Depreciation		Crest Realty LLC		58,718	58,718	9
10	V	32 Interest		Crest Realty LLC		107,875	107,875	10
11	V	33 Real Estate Taxes		Crest Realty LLC		469	469	11
12	V	34 Rent	300,000	Crest Realty LLC			(300,000)	12
13	V							13
14	Total		\$ 507,689			\$ 358,101	\$ * (149,589)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Maintenance	\$	Crest Manangement		\$		15
16	V	19 Professional Services	334,830	Crest Manangement			(334,830)	16
17	V	21 Clerical & General Office Expenses		Crest Manangement				17
18	V	22 Employee Benefits & Payroll Taxes		Crest Manangement				18
19	V	24 Travel and Seminar		Crest Manangement				19
20	V	36 Other (specify):*		Crest Manangement				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		\$ 334,830			\$ 0	\$ * (334,830)	39

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

Facility Name & ID Number

SUNRISE SKILLED NUR REHAB

# 0055905

Report Period Beginning:

01/01/20

Ending:

12/31/20

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			Taylorville Care Center	Taylorville				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 SUNRISE SKILLED NUR REHAB # 0055905 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

# 0055905

Report Period Beginning:

01/01/20

Ending: 12/31/20

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

Facility Name & ID Number

SUNRISE SKILLED NUR REHAB

# 0055905

Report Period Beginning:

01/01/20

Ending:

12/31/20

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Mortgage		No	Mortgage	Various		\$	\$ 2,483,223			\$	114,113						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$ 2,483,223			\$	114,113						
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,483,223			\$	114,113						

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

\* 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.)

**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.**

1. Real Estate Tax accrual used on 2019 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.)	\$	<b>31,739</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>31,739</b>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>(300)</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>31,439</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	_____	8
	2016	_____	9
	2017	_____	10
	2018	_____	11
	2019	_____	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2019	\$ _____	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.**

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SUNRISE SKILLED NUR REHAB COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0055905

CONTACT PERSON REGARDING THIS REPORT AARON MAUER

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-000-148-01</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>31,739.16</u>	\$ <u>31,739.16</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>31,739.16</u></u>	\$ <u><u>31,739.16</u></u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**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 SUNRISE SKILLED NUR REHAB

# 0055905 Report Period Beginning:

01/01/20 Ending:

12/31/20

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 3 is shaded and labeled 'TOTALS'.

Facility Name & ID Number **SUNRISE SKILLED NUR REHAB**

# **0055905**

Report Period Beginning:

**01/01/20**

Ending:

**12/31/20**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	101	2019		\$ 714,930	\$ 18,332	39	\$ 18,332	\$ (0)	\$ 35,892	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	sprinkler system repairs throughout the building		2020	1,766	49	39	23	(26)	49	9
10	facility signage throughout the building		2020	8,688	145	39	111	(33)	145	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.

\*\*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 **SUNRISE SKILLED NUR REHAB**

# **0055905**

Report Period Beginning:

01/01/20

Ending:

12/31/20

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

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

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	\$ 134,049	\$ 40,386	\$ 26,810	\$ (13,576)	5	\$ 29,130	71
72	Current Year Purchases	76,163	6,044	7,616	1,573	5	6,833	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 210,212	\$ 46,430	\$ 34,426	\$ (12,003)		\$ 35,963	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				\$	\$	\$	\$		\$	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)	\$ 935,596	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,955	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 52,892	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,064)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 72,049	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: NA

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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ 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	<b>TOTAL</b>		\$	\$	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 SUNRISE SKILLED NUR REHAB # 0055905 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,768	\$ 300,122	\$	3,768	\$ 300,122	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		642	62,910		642	62,910	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,924	231,220		2,924	231,220	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				97,992		97,992	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Ray</u>	39-2					1,911		1,911	12
13	Other (specify): <u>Lab</u>	39-2					6,206		6,206	13
14	<b>TOTAL</b>			\$	7,334	\$ 594,252	\$ 106,109	7,334	\$ 700,361	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.

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 188,482	\$ 523,299	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,725,424	1,725,424	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	147,971	147,971	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	82,940	82,940	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 2,144,817</b>	<b>\$ 2,479,634</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,683	13
14	Buildings, at Historical Cost		714,930	14
15	Leasehold Improvements, at Historical Cost	10,454	10,454	15
16	Equipment, at Historical Cost	76,163	210,212	16
17	Accumulated Depreciation (book methods)	(7,033)	(72,056)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,128	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <b>Goodwill</b>		1,637,538	22
23	Other(specify): <b>Replacement Reserve</b>		14,725	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 79,584</b>	<b>\$ 2,673,614</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,224,401</b>	<b>\$ 5,153,248</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 411,606	\$ 412,384	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,995	43,995	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,752	109,752	30
31	Accrued Taxes Payable (excluding real estate taxes)	76,332	76,332	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,439	31,439	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 673,124</b>	<b>\$ 673,902</b>	<b>38</b>
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	537,520	537,520	39
40	Mortgage Payable		2,483,223	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 537,520</b>	<b>\$ 3,020,743</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,210,644</b>	<b>\$ 3,694,645</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 1,013,757</b>	<b>\$ 1,458,603</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,224,401</b>	<b>\$ 5,153,248</b>	<b>48</b>

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(22,554)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(22,554)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,050,597</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(14,285)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,036,312</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Rounding</b>	<b>(1)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(1)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,013,757</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,989,216	1
2	Discounts and Allowances for all Levels	(13,057)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,976,159	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	471,693	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 471,693	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	680,045	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	92	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	809	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 680,946	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,937	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,937	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,132,735	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	820,342	31
32	Health Care	2,871,928	32
33	General Administration	1,678,315	33
<b>B. Capital Expense</b>			
34	Ownership	357,535	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	354,018	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,082,138	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,050,597	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,050,597	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,646,852	44
45	Private Pay - Net Inpatient Revenue	877,200	45
46	Medicare - Net Inpatient Revenue	1,991,644	46
47	Other-(specify) <u>Insurance</u>	314,424	47
48	Other-(specify) <u>Hospice</u>	146,039	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,976,159	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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**

# **0055905**

Report Period Beginning: **01/01/20**

Ending:

**12/31/20**

**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	1,912	2,114	\$ 92,548	\$ 43.78	1
2	Assistant Director of Nursing	1,284	1,369	36,418	26.60	2
3	Registered Nurses	7,998	8,701	217,231	24.97	3
4	Licensed Practical Nurses	18,174	20,040	471,822	23.54	4
5	CNAs & Orderlies	58,428	63,415	883,279	13.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,810	2,015	28,341	14.07	9
10	Activity Assistants	2,085	2,100	19,431	9.25	10
11	Social Service Workers	1,896	1,953	40,307	20.64	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,086	49,146	23.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,254	13,717	132,758	9.68	15
16	Dishwashers					16
17	Maintenance Workers	3,550	3,662	60,345	16.48	17
18	Housekeepers	11,015	11,506	109,773	9.54	18
19	Laundry					19
20	Administrator	1,993	2,069	80,697	39.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,489	5,494	93,775	17.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS</u>	1,896	2,091	49,171	23.52	33
34	TOTAL (lines 1 - 33)	131,816	142,332	\$ 2,365,042 *	\$ 16.62	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 15,000	9-3	36
37	Medical Records Consultant			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			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 15,000		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**# **0055905**Report Period Beginning: **01/01/20**Ending: **12/31/20****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions												
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount												
ZAERR SAWYER L	Administrator	0	\$ 60,238	Workers' Compensation Insurance	\$ 74,896	IDPH License Fee	\$												
MELTON BRANDIA	Administrator	0	24,100	Unemployment Compensation Insurance	25,074	Advertising: Employee Recruitment													
				FICA Taxes	216,963	Health Care Worker Background Check													
				Employee Health Insurance	133,720	(Indicate # of checks performed _____)													
				Employee Meals		Patient Background Checks													
				Illinois Municipal Retirement Fund (IMRF)*		HCCI	15,147												
				Other Benefits	51,429	IL Council	891												
				Background Checks	699	License Fee	2,713												
				COVID Benefits	23,010														
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 84,338	TOTAL (agree to Schedule V, line 22, col.8)			\$ 525,791	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,751									
(List each licensed administrator separately.)								Less: Public Relations Expense ( )											
B. Administrative - Other								Non-allowable advertising ( )											
Description			Amount					Yellow page advertising ( )											
			\$																
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**												
(Attach a copy of any management service agreement)				Description				Amount											
C. Professional Services				Description				Line #				Amount							
Vendor/Payee			Type	Amount															
Crest Managment			Management Fees	\$ 334,830								Out-of-State Travel				\$			
Gutnicki LLP			Legal Fees	112															
Falcon, Rappaport & Berkin			Legal Fees	500															
CFG			Legal Fees	6734.98								In-State Travel							
Pease			Accounting fees	6,255								Travel & Seminar				3,514			
GGm			Accounting fees	6,000								Seminar Expense							
See attached Schedule				19,962								Entertainment Expense ( )							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 374,393	TOTAL				\$				TOTAL (agree to Sch. V, line 24, col. 8)				\$ 3,514			
(For legal fee disclosure, see page 39 of instructions)																			

\* Attach copy of IMRF notifications

\*\*See instructions.

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
<u>Compliance Consulting group</u>	<u>Professional fees</u>	<u>\$ 7,200</u>
<u>MTS Consulting</u>	<u>Professional fees</u>	<u>2,033</u>
<u>CFG</u>	<u>Professional fees</u>	<u>2,967</u>
<u>Vcorp</u>	<u>Professional fees</u>	<u>460.1</u>
<u>LTC Consulting</u>	<u>Professional fees</u>	<u>3,221</u>
<u>Pease</u>	<u>Professional fees</u>	<u>389</u>
<u>Dovid Stern</u>	<u>Professional fees</u>	<u>19</u>
<u>Activated Insights</u>	<u>Professional fees</u>	<u>722</u>
<u>Pathway Health Services</u>	<u>Professional fees</u>	<u>200</u>
<u>Apex Global Solutions</u>	<u>Professional fees</u>	<u>2,750</u>
		19,962.03

Facility Name &amp; ID Number SUNRISE SKILLED NUR REHAB

# 0055905

Report Period Beginning: 01/01/20

Ending: 12/31/20

**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. HCCI \$15,147
- (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? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,486 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. \$ 162,607  
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  
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.