

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841 Report Period Beginning: 8/1/08 Ending: 7/31/09

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 12/12/08

	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	<u>25</u>	Skilled (SNF)	<u>41</u>	<u>12,837</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>74</u>	Intermediate (ICF)	<u>58</u>	<u>23,298</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF		<u>1,141</u>	<u>3,592</u>	<u>4,733</u>	8
9	SNF/PED					9
10	ICF	<u>12,143</u>	<u>5,653</u>		<u>17,796</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,143</u>	<u>6,794</u>	<u>3,592</u>	<u>22,529</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.35%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 10/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES Date SEE ATTACHED 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 3,592

Medicare Intermediary NATIONAL GOVERNMENT SERVICES - KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 07/31/09 Fiscal Year: 07/31/09

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

Facility Name & ID Number **SUNRISE MANOR OF VIRDEN** # **0025841** Report Period Beginning: **8/1/08** Ending: **7/31/09**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	128,531	22,035	7,151	157,717		157,717		157,717		1
2	Food Purchase		138,983		138,983		138,983	(4,031)	134,952		2
3	Housekeeping	43,672	15,013		58,685		58,685		58,685		3
4	Laundry	34,899	5,251		40,150		40,150		40,150		4
5	Heat and Other Utilities			101,093	101,093		101,093		101,093		5
6	Maintenance	55,000	31,908	78,133	165,041		165,041	12,649	177,690		6
7	Other (specify):* UTILITY WORKERS	36,246			36,246		36,246		36,246		7
8	TOTAL General Services	298,348	213,190	186,377	697,915		697,915	8,618	706,533		8
	B. Health Care and Programs										
9	Medical Director			11,400	11,400		11,400	2,358	13,758		9
10	Nursing and Medical Records	970,263	279,732	356,276	1,606,271	(171,450)	1,434,821	5,718	1,440,539		10
10a	Therapy	51,841	9,681	533,546	595,068	(533,546)	61,522		61,522		10a
11	Activities	62,614	3,774		66,388		66,388		66,388		11
12	Social Services	51,221		5,875	57,096		57,096		57,096		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,135,939	293,187	907,097	2,336,223	(704,996)	1,631,227	8,076	1,639,303		16
	C. General Administration										
17	Administrative	65,959		13,825	79,784	2,799	82,583	41,318	123,901		17
18	Directors Fees										18
19	Professional Services			183,658	183,658		183,658	(170,084)	13,574		19
20	Dues, Fees, Subscriptions & Promotions			59,087	59,087		59,087	(45,570)	13,517		20
21	Clerical & General Office Expenses	77,518	17,821	9,244	104,583		104,583	35,110	139,693		21
22	Employee Benefits & Payroll Taxes			254,872	254,872		254,872	(310)	254,562		22
23	Inservice Training & Education			4,466	4,466		4,466	541	5,007		23
24	Travel and Seminar			8,834	8,834	(4,270)	4,564	1,023	5,587		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,301	52,301		52,301	381	52,682		26
27	Other (specify):* PER DESK REVIEW			88,630	88,630		88,630	(69,369)	19,261		27
28	TOTAL General Administration	143,477	17,821	674,917	836,215	(1,471)	834,744	(206,960)	627,784		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,577,764	524,198	1,768,391	3,870,353	(706,467)	3,163,886	(190,266)	2,973,620		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			34,844	34,844		34,844	39,400	74,244			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,940	28,940		28,940	(28,940)				32
33	Real Estate Taxes			26,014	26,014		26,014		26,014			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(138,547)	5,453			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			233,798	233,798		233,798	(128,087)	105,711			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					706,467	706,467		706,467			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,203	54,203	706,467	760,670		760,670			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,577,764	524,198	2,056,392	4,158,354		4,158,354	(318,353)	3,840,001			45

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

SUNRISE MANOR OF VIRDEN

ID# 0025841

Report Period Beginning: 8/1/08

Ending: 7/31/09

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
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNRISE MANOR OF VIRDEN# 0025841

Report Period Beginning:

8/1/08

Ending:

7/31/09

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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,712)	0	0	0	0	0	0	0	0	0	0	(2,712)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,712)	0	0	0	0	0	0	0	0	0	0	(2,712)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	459	0	0	0	0	0	0	0	0	0	459	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(95)	(169,951)	0	0	0	0	0	0	0	0	0	(170,046)	19
20	Fees, Subscriptions & Promotions	(45,639)	0	0	0	0	0	0	0	0	0	0	(45,639)	20
21	Clerical & General Office Expenses	(7,564)	0	0	0	0	0	0	0	0	0	0	(7,564)	21
22	Employee Benefits & Payroll Taxes	0	(19,261)	0	0	0	0	0	0	0	0	0	(19,261)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(459)	0	0	0	0	0	0	0	0	0	(459)	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):*	(88,630)	19,261	0	0	0	0	0	0	0	0	0	(69,369)	27
28	TOTAL General Administration	(141,928)	(169,951)	0	(311,879)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(144,640)	(169,951)	0	(314,591)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNRISE MANOR OF VIRDEN# 0025841

Report Period Beginning:

8/1/08

Ending:

7/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	37,801	121	0	0	0	0	0	0	0	0	0	37,922	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,273)	333	0	0	0	0	0	0	0	0	0	(28,940)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(144,000)	0	0	0	0	0	0	0	0	0	(144,000)	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	TOTAL Ownership	8,528	(143,546)	0	(135,018)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(136,112)	(313,497)	0	0	0	0	0	0	0	0	0	(449,609)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN	91.0%	HILLTOP NURSING HOME, INC.	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
DAVID KLEIN	4.5%	JACKSONVILLE CONVALESCENT CENTER, INC.	JACKSONVILLE	Sunrise Property	SPRINGFIELD	LEASOR
PAULA K. JENNINGS	4.5%	MEADOW MANOR, INC.	TAYLORVILLE			
		MENARD CONVALESCENT CENTER, INC.	PETERSBURG			

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)	
1	V	34 RENT	\$ 144,000	SUNRISE PROPERTY	100.00%	\$	\$ (144,000)	1
2	V	30 DEPRECIATION		SUNRISE PROPERTY	100.00%	121	121	2
3	V	32 INTEREST		SUNRISE PROPERTY	100.00%	333	333	3
4	V							4
5	V	19 MANAGEMENT FEE	177,863	NURSING HOME MANAGERS, INC.	91.00%		(177,863)	5
6	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	91.00%	132,575	132,575	6
7	V	19 ACCOUNTING		NURSING HOME MANAGERS, INC. - DIRECT ALLOCATIO	91.00%	7,912	7,912	7
8	V	24 TRAVEL	459	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(459)	8
9	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		459	459	9
10	V	22 EMPL. BENEFITS & PR TAXES	19,261	TO TRANSFER HOME OFFICE EMPLOYEE BENEFITS			(19,261)	10
11	V	27 OTHER - GENERAL ADMIN.		AND PAYROLL TAXES TO OTHER - PER DESK REVIEW		19,261	19,261	11
12	V							12
13	V							13
14	Total		\$ 341,583			\$ 160,661	\$ * (180,922)	14

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

Facility Name & ID Number

SUNRISE MANOR OF VIRDEN

#

0025841

Report Period Beginning:

8/1/08

Ending:

7/31/09

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	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.50					\$ 20,281	17 - 7	1	
2											2	
3											3	
4			JERRY JENNINGS WAS PAID BY NURSING HOME MANAGERS, INC.,									4
5			A RELATED ORGANIZATION. COMPENSATION OF \$107,674 FOR									5
6			JERRY JENNINGS WAS ALLOCATED AMONG THE FIVE RELATED									6
7			NURSING HOMES BASED ON 35 HOURS PER WEEK.									7
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 20,281		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 MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/08

Ending: 7/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization NURSING HOME MANAGERS, INC.
 Street Address 2653 WEST LAWRENCE - SUITE B
 City / State / Zip Code SPRINGFIELD, IL 62704
 Phone Number (217) 787-8530
 Fax Number (217) 787-9840

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	SEE ATTACHED SCHEDULES				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/08

Ending:

7/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	OWNERS	X		ACQUISITION	VARIES	10/1/85	\$ 800,000	\$ 5,550	DEMAND	6.0000	\$ 333	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	SUNRISE PROPERTY	X		WORKING CAPITAL		09/20/04	75,000	896,451	DEMAND	4.0000	28,940	6							
7	STOCKHOLDERS	X		WORKING CAPITAL		03/30/06	30,000	161,000				7							
8												8							
9	TOTAL Facility Related						\$ 905,000	\$ 1,063,001			\$ 29,273	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 905,000	\$ 1,063,001			\$ 29,273	15							

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

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0025841

Report Period Beginning:

8/1/08

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7/31/09

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).

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>1985</u>	<u>\$ 5,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 5,000	3

Facility Name & ID Number **SUNRISE MANOR OF VIRDEN**# **0025841**

Report Period Beginning:

8/1/08

Ending:

7/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	99		1985	1970	\$ 885,000	\$	30	\$ 29,500	\$ 29,500	\$ 708,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		AIR CONDITIONING	1981		2,179		8			2,179	9
10		IMPROVEMENT	1981		5,664		15			5,664	10
11		AIR CONDITIONING	1983		1,734		10			1,734	11
12		EXHAUST FAN & IMPROVEMENT	1984		2,064		15			2,064	12
13		ROOF	1985		29,004		15			29,004	13
14		BLACKTOP	1985		16,000		15			16,000	14
15		LANDSCAPING	1985		2,400		10			2,400	15
16		TILE	1986		2,508		15			2,508	16
17		AIR CONDITIONING	1986		573		8			573	17
18		CIRCULATING PUMPS	1986		918		15			918	18
19		WATER HEATER	1987		1,705	54	15		(54)	1,705	19
20		SEWER & MANHOLE	1988		4,843	154	15		(154)	4,843	20
21		FIRE ALARM ADJUSTMENT	1989		1,388	44	15		(44)	1,388	21
22		SPRINKLER MAINTENANCE	1990		735	23	10		(23)	735	22
23		ROOF	1990		11,247	357	15		(357)	11,247	23
24		SPRINKLER & DETECTORS	1991		2,684	85	15		(85)	2,684	24
25		DOOR ALARM, TOILET, ETC.	1993		2,867	74	15		(74)	2,867	25
26		ROOF, AIR CONDITIONING, KITCHEN	1995		16,554	424	15	1,103	679	16,004	26
27		SMOKE DOORS	1997		4,043	104	15	270	166	3,101	27
28		ROOF	1998		10,655	273	15	710	437	8,168	28
29		DOOR FRAMES	1998		4,379	112	15	292	180	3,357	29
30		GUTTERS	1999		800	21	15	53	32	560	30
31		AIR CONDITIONING	1999		17,091	438	10	854	416	17,091	31
32		WATER HEATER, DOOR , PLUMBING	2000		13,377	344	15	892	548	8,493	32
33		AIR CONDITIONING	2001		2,606	67	15	173	106	1,375	33
34		AIR CONDITIONING	2004		4,707	121	10	470	349	2,393	34
35		ROOF	2004		3,836	98	15	255	157	1,257	35
36		BOILER MAINTENANCE	2004		8,893	228	15	593	365	2,816	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	SMOKE DETECTORS & SPRINKLER SYSTEM	2005	\$ 9,831	\$ 252	15	\$ 656	\$ 404	\$ 2,865	37
38	DRY PIPE VALVE REPLACEMENT	2005	2,144	55	15	143	88	572	38
39	FIRE ALARM SYSTEM	2005	6,127	157	15	409	252	1,498	39
40	GREASE TRAP	2006	1,879	48	10	188	140	579	40
41	ROOF	2007	74,832	1,919	15	4,989	3,070	7,207	41
42	COMPRESSOR - ROOFTOP UNIT	2008	5,779	148	10	578	430	674	42
43	DOOR LOCKS & ALARMS	2009	3,435	70	15	172	102	172	43
44	ROOF	2009	11,700	238	20	488	250	488	44
45	HANDRAILS	2009	8,872	104	15	296	192	296	45
46	SPRINKLERS	2009	12,842	14	20		(14)		46
47	BACKFLOW PREVENTOR	2009	5,488	6	15		(6)		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)		\$ 1,203,383	\$ 6,032		\$ 43,084	\$ 37,052	\$ 875,479	70

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

Facility Name & ID Number **SUNRISE MANOR OF VIRDEN**

0025841

Report Period Beginning:

8/1/08

Ending:

7/31/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 298,406	\$ 23,932	\$ 29,439	\$ 5,507	VARIOUS	\$ 178,501	71
72	Current Year Purchases	9,192	5,001	243	(4,758)	VARIOUS	243	72
73	Fully Depreciated Assets	280,241					280,241	73
74								74
75	TOTALS	\$ 587,839	\$ 28,933	\$ 29,682	\$ 749		\$ 458,985	75

D. Vehicle Depreciation (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)	\$ 1,796,222	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,965	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,766	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 37,801	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,334,464	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: SUNRISE PROPERTY

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:	<u>1970</u>	<u>99</u>	<u>08/01/85</u>	\$ <u>144,000</u>		<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>99</u>		\$ <u>144,000</u>			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: _____*

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: INCLUDED IN THE ABOVE AMOUNT

(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

10. Effective dates of current rental agreement:

Beginning 08/01/08

Ending 07/31/09

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

Fiscal Year Ending Annual Rent

12. 07/31/2010 \$ 144,000

13. 07/31/2011 \$ 144,000

14. 07/31/2012 \$ 144,000

* 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.

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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

	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 - 8	hrs	\$	3,264	\$ 207,936	\$	3,264	\$ 207,936	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		1,421	81,872		1,421	81,872	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		4,853	243,738		4,853	243,738	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 8	# of prescripts				127,540		127,540	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance, Lab, X-Ray</u>	39 - 8					26,182		26,182	12
13	Other (specify): <u>Oxy, Supplies, Other</u>	39 - 8					19,199		19,199	13
14	TOTAL			\$	9,538	\$ 533,546	\$ 172,921	9,538	\$ 706,467	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning: 8/1/08

Ending: 7/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 7/31/09 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 65,670	\$ 71,466	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	775,651	775,651	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,930	8,930	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 850,251	\$ 856,047	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		5,000	13
14	Buildings, at Historical Cost		892,827	14
15	Leasehold Improvements, at Historical Cost	310,555	310,555	15
16	Equipment, at Historical Cost	437,938	586,438	16
17	Accumulated Depreciation (book methods)	(489,416)	(1,529,475)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 259,077	\$ 265,345	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,109,328	\$ 1,121,392	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 857,936	\$ 857,936	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,057,451	166,550	29
30	Accrued Salaries Payable	28,112	28,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,280	2,280	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,773	40,773	32
33	Accrued Interest Payable		28	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)	\$ 1,986,552	\$ 1,095,679	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,986,552	\$ 1,095,679	46
47	TOTAL EQUITY(page 18, line 24)	\$ (877,224)	\$ 25,713	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,109,328	\$ 1,121,392	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (453,731)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (453,731)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(423,493)	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)	\$ (423,493)	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)	\$ (877,224)	24 *

* 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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,757,743	1
2	Discounts and Allowances for all Levels	(200,489)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,557,254	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	159,163	6
7	Oxygen	4,431	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 163,594	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	2,712	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,712	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,388	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,388	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 1,319 - ADMIT FEE 525 - W/A 48	1,892	28
28a	BAD DEBT RECOVERY 30 - OLD CHECKS 6,991	7,021	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,913	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,734,861	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	697,915	31
32	Health Care	2,336,223	32
33	General Administration	836,215	33
B. Capital Expense			
34	Ownership	233,798	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,158,354	40
41	Income before Income Taxes (line 30 minus line 40)**	(423,493)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (423,493)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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 MANOR OF VIRDEN**

0025841

Report Period Beginning:

8/1/08

Ending:

7/31/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,006	2,086	\$ 55,343	\$ 26.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,747	6,394	140,925	22.04	3
4	Licensed Practical Nurses	17,382	18,348	326,684	17.80	4
5	CNAs & Orderlies	39,071	40,244	447,311	11.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,254	4,517	51,841	11.48	8
9	Activity Director	1,773	1,781	20,007	11.23	9
10	Activity Assistants	5,266	5,474	42,607	7.78	10
11	Social Service Workers	3,737	4,148	51,221	12.35	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,148	30,270	14.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,953	11,158	98,261	8.81	15
16	Dishwashers					16
17	Maintenance Workers	5,230	5,271	55,000	10.43	17
18	Housekeepers	5,056	5,239	43,672	8.34	18
19	Laundry	3,653	3,878	34,899	9.00	19
20	Administrator	1,966	2,086	65,959	31.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,880	6,447	77,518	12.02	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Utility Workers</u>	4,524	4,546	36,246	7.97	33
34	TOTAL (lines 1 - 33)	118,481	123,765	\$ 1,577,764 *	\$ 12.75	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	198	\$ 7,151	1 - 3	35
36	Medical Director	120	11,400	9 - 3	36
37	Medical Records Consultant	6	150	10 - 3	37
38	Nurse Consultant	392	12,853	10 - 3	38
39	Pharmacist Consultant	88	2,725	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	92	5,875	12 - 3	45
46	Other(specify)				46
47	<u>ADMINISTRATIVE CONSULTANT</u>	584	13,825	17 - 3	47
48	<u>PSYCH CONSULTANT</u>	203	16,755	10 - 3	48
49	TOTAL (lines 35 - 48)	1,683	\$ 70,734		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	532	\$ 18,894	10 - 3	50
51	Licensed Practical Nurses	1,016	33,941	10 - 3	51
52	Certified Nurse Assistants/Aides	13,565	270,958	10 - 3	52
53	TOTAL (lines 50 - 52)	15,113	\$ 323,793		53

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/08

Ending:

7/31/09

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? NO
If YES, give association name and amount. _____
- (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? _____
- (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? _____
- (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? 15 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,782 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
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? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,712
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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? 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 2 - SCHEDULE III - QUESTION A

LICENSURE / CERTIFICATION		
8/1/08- 12/11/08	SKILLED BEDS 25 X 133 DAYS =	3,325
12/12/08 - 7/31/09	SKILLED BEDS 41 X 232 DAYS =	<u>9,512</u>
TOTAL SKILLED BED DAYS DURING REPORT PERIOD		<u>12,837</u>
8/1/08- 12/11/08	INTERMEDIATE BEDS 74 X 133 DAYS =	9,842
12/12/08 - 7/31/09	INTERMEDIATE BEDS 58 X 232 DAYS =	<u>13,456</u>
TOTAL INTERMEDIATE BED DAYS DURING REPORT PERIOD		<u>23,298</u>

PAGE 2 - SCHEDULE III - QUESTION J

FACILITY WAS LEASED 10/01/80 FROM NON-RELATED PARTY
 FACILITY WAS PURCHASED 07/23/85

PAGE 3 & 4 - SCHEDULE V

LINE 27 - OTHER - GENERAL AND ADMINISTRATION	
SALES TAX	\$ 5,863
BAD DEBTS	<u>82,767</u>
LINE 27 - COLUMN 3	<u>\$ 88,630</u>

LINE 23 - INSERVICE TRAINING & EDUCATION	
FOOD SERVICE SANITATION COURSE	\$ 220
INHAA CONVENTION & CONFERENCE	220
DON LUCHEON	16
REHAB & RESTORATIVE COURSE	600
ALZHEIMER CONFERENCE	80
LTC SURVEYOR WORKSHOP	145
MANAGEMENT SEMINAR	149
ACCUCARE SOFTWARE TRAINING	525
SILVERSTEP - ONLINE TRAINING	1,932
PYSCHOSOCIAL SURVEY SEMINAR	369
INSERVICES BY HOME OFFICE	210
NURSING HOME MANAGERS ALLOCATION	<u>541</u>
LINE 23 - COLUMN 8	<u>\$ 5,007</u>

PAGE 3 & 4 - SCHEDULE V

COLUMN 5 - RECLASSIFICATION

TRANSFER FROM:		LINE #
MEDICARE AMBULANCE	\$ (12,596)	10
MEDICARE OTHER ANCILLARY	(56)	10
MEDICARE X -RAYS	(3,099)	10
MEDICARE SUPPLIES	(4,558)	10
MEDICARE LABS	(10,487)	10
MEDICARE DRUGS & IV'S	(127,540)	10
OXYGEN	(14,585)	10
PHYSICAL THERAPY	(243,738)	10A
SPEECH THERAPY	(81,872)	10A
OCCUPATIONAL THERAPY	<u>(207,936)</u>	10A
TRANSFER TO: ANCILLARY SERVICES	<u>\$ 706,467</u>	39
TRANSFER TO:		
NURSING CONSULTANT TRAVEL	\$ 1,471	10
ADMINISTRATIVE CONSULTANT TRAVEL	<u>2,799</u>	17
TRANSFER FROM : TRAVEL	<u>\$ (4,270)</u>	24

PAGE 13 - SCHEDULE XI - SECTION E
RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 72,766
NURSING HOME MANAGERS ALLOCATION	<u>1,478</u>
SCHEDULE V- LINE 30 - COLUMN 8	<u>\$ 74,244</u>

PAGE 19 - SCHEDULE XVII - LINE 41
RECONCILIATION OF INCOME

LINE 41 - NET INCOME	\$ (423,493)
* ACCRUED MANAGEMENT FEE - 07/31/08	(71,111)
* ACCRUED MANAGEMENT FEE - 07/31/09	56,974
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(2,388)
TAXABLE INCOME	<u>\$ (440,018)</u>

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

PAGE 21 - SCHEDULE XIX - SECTION F
DUES, FEES, SUBSCRIPTIONS & PROMOTIONS

YELLOW PAGES	\$ 1,060
PUBLIC RELATIONS	44,579
INHAA DUES	100
BOILER LICENSE	200
MACOUPIN COUNTY PUBLIC HEALTH	85
FRANCHISE FEE	<u>325</u>
	<u>\$ 46,349</u>

PAGE 21 - SCHEDULE XIX - SECTION G
SCHEDULE OF TRAVEL AND SEMINAR

ACTIVITY & SOCIAL SERVICE MILEAGE REIMB.	\$ 628
COMMUNITY RELATIONS MILEAGE REIMB.	2,323
DON & ADMINISTRATOR MILEAGE REIMB.	363
MAINTENANCE MILEAGE REIMBURSEMENT	755
MEETINGS MILEAGE REIMBURSEMENT	230
MISCELLANEOUS MILEAGE REIMBURSEMENT	<u>265</u>
	<u>\$ 4,564</u>

PAGE 23 - SCHEDULE XX - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENT WORKED BASED UPON TIME CARDS.

CENTRAL OFFICE COST ALLOCATION
 SUNRISE
 2008

	AUG 08	SEPT	OCT	NOV	DEC 08	JAN 09	FEB	MARCH	APRIL	MAY	JUNE	JULY 09	2008 TOTAL	LINE #
SALARIES-ADMIN	820	814	789	833	816	\$2,340	\$2,273	\$2,324	\$2,374	\$2,448	\$2,410	\$2,335	\$20,578	17
SALARIES-CLERIC	3,207	3,185	3,085	3,256	3,192	3,211	3,119	3,188	3,258	3,359	3,307	3,204	38,570	21
SALARIES-CONTR	2,486	2,469	2,391	2,524	2,474	1,126	1,093	1,117	1,142	1,177	1,159	1,123	20,281	17
SALARIES-NURSE	806	801	776	818	802	243	236	241	247	254	250	243	5,718	10
ACCOUNTING	(123)	(122)	(118)	(125)	(122)	81	79	81	82	85	84	81	(38)	19
WORK COMP INS	(18)	(17)	(17)	(18)	(17)	(32)	(31)	(31)	(32)	(33)	(33)	(32)	(310)	22
SUPPLIES	221	220	213	225	220	81	78	80	82	84	83	81	1,668	21
TELEPHONE	172	171	165	174	171	225	218	223	228	235	231	224	2,436	21
EMPL BENEFITS	1,421	1,411	1,367	1,443	1,414	845	820	839	857	883	870	843	13,013	22
PAYROLL TAXES	603	599	580	612	600	461	448	458	468	482	475	460	6,248	22
TRAVEL	141	140	135	143	140	111	108	110	113	116	114	111	1,482	24
IN SERVICE	57	57	55	58	57	36	35	36	37	38	37	36	541	23
MEDICAL CONSULT	(283)	(281)	(272)	(287)	(281)	192	187	191	195	201	198	192	(48)	9
MACHINE RENTAL	944	937	908	958	939	792	769	786	803	828	816	790	10,272	6
OWNERS COMP	0	0	0	0	0	0	0	0	0	0	0	0	0	17
INS-PROP,LIAB,WC	77	76	74	78	76	0	0	0	0	0	0	0	381	26
DEPRECIATION	24	23	23	24	24	193	187	191	196	202	199	192	1,478	30
RENT	366	364	352	372	364	515	501	512	523	539	531	514	5,453	34
MAINTENANCE	(8)	(8)	(8)	(8)	(8)	343	333	340	348	359	353	342	2,377	6
FEES & PUBLICAT	10	10	10	10	10	3	3	3	3	3	3	3	69	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
MEDICAL DIRECTOR	485	481	466	492	482	0	0	0	0	0	0	0	2,406	9
TOTAL	11,409	11,329	10,975	11,582	11,353	\$10,767	\$10,457	\$10,689	\$10,923	\$11,261	\$11,088	\$10,742	\$132,575	
FIXED ASSETS	0	0	0	0	0								132,575	
EQUIP - PRIOR	13,124	13,032	12,625	13,324	13,060	12,499	12,139	12,408	12,680	13,073	12,872	12,470	12,775	
EQUIP - CURR	4,173	4,143	4,014	4,236	4,152	258	250	256	262	270	266	3,965	2,187	
EQUIP - FULLY DEP	5,066	5,031	4,874	5,144	5,042	4,825	4,686	4,790	4,895	5,047	4,969	4,814	4,932	
BLDG - PRIOR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	1,293	1,284	1,244	1,313	1,287	1,231	1,196	1,223	1,249	1,288	1,268	1,229	1,259	

OCCUPIED DAYS 2008	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,239	2,512	2,573		1,460	1,936	10,720
FEBRUARY	2,140	2,453	2,399		1,407	1,909	10,308
MARCH	2,260	2,436	2,476		1,475	1,985	10,632
APRIL	2,248	2,186	2,456		1,483	1,867	10,240
MAY	2,356	2,118	2,479		1,731	2,002	10,686
JUNE	2,283	2,143	2,410		1,661	1,881	10,378
JULY	2,369	2,288	2,429		1,632	1,992	10,710
AUGUST	2,137	2,345	2,451		1,620	2,036	10,589
SEPTEMBER	1,988	2,459	2,376		1,627	1,994	10,444
OCTOBER	1,980	2,561	2,592		1,605	1,983	10,721
NOVEMBER	1,777	2,428	2,482		1,567	2,002	10,256
DECEMBER	1,901	2,534	2,445		1,611	2,009	10,500
TOTAL	25,678	28,463	29,568	0	18,879	23,596	126,184 126,184

OCCUPIED DAYS 2009	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,861	2,413	2,389		1,630	1,859	10,152
FEBRUARY	1,752	2,160	2,088		1,341	1,588	8,929
MARCH	1,882	2,368	2,469		1,567	1,841	10,127
APRIL	1,701	2,113	2,469		1,466	1,768	9,517
MAY	1,816	2,090	2,434		1,499	1,857	9,696
JUNE	1,718	2,003	2,476		1,350	1,754	9,301
JULY	1,838	2,163	2,658		1,510	1,826	9,995
AUGUST	1,833	2,214	2,647		1,481	1,952	10,127
SEPTEMBER	0	0	0		0	0	0
OCTOBER	0	0	0		0	0	0
NOVEMBER	0	0	0		0	0	0
DECEMBER							0
TOTAL	14,401	17,524	19,630	0	11,844	14,445	77,844 77,844

ALLOCATION PERCENTAGE 2008	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	20.89%	23.43%	24.00%	13.62%	18.06%	100.00%
FEBRUARY	20.76%	23.80%	23.27%	13.65%	18.52%	100.00%
MARCH	21.26%	22.91%	23.29%	13.87%	18.67%	100.00%
APRIL	21.95%	21.35%	23.98%	14.48%	18.23%	100.00%
MAY	22.05%	19.82%	23.20%	16.20%	18.73%	100.00%
JUNE	22.00%	20.65%	23.22%	16.01%	18.12%	100.00%
JULY	22.12%	21.36%	22.68%	15.24%	18.60%	100.00%
AUGUST	20.18%	22.15%	23.15%	15.30%	19.23%	100.00%
SEPTEMBER	19.03%	23.54%	22.75%	15.58%	19.09%	100.00%
OCTOBER	18.47%	23.89%	24.18%	14.97%	18.50%	100.00%
NOVEMBER	17.33%	23.67%	24.20%	15.28%	19.52%	100.00%
DECEMBER	18.10%	24.13%	23.29%	15.34%	19.13%	100.00%

ALLOCATION PERCENTAGE 2009	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.33%	23.77%	23.53%	16.06%	18.31%	100.00%
FEBRUARY	19.62%	24.19%	23.38%	15.02%	17.78%	100.00%
MARCH	18.58%	23.38%	24.38%	15.47%	18.18%	100.00%
APRIL	17.87%	22.20%	25.94%	15.40%	18.58%	100.00%
MAY	18.73%	21.56%	25.10%	15.46%	19.15%	100.00%
JUNE	18.47%	21.54%	26.62%	14.51%	18.86%	100.00%
JULY	18.39%	21.64%	26.59%	15.11%	18.27%	100.00%
AUGUST	18.10%	21.86%	26.14%	14.62%	19.28%	100.00%