

Facility Name & ID Number SUNSET HOME

0011643 Report Period Beginning: 10/1/08 Ending: 09/30/09

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 1/29/09

	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	19	Skilled (SNF)	64	17,915	1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	118	47,184	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	0	3,751	5
6		ICF/DD 16 or Less			6
7	202	TOTALS	182	68,850	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		15	4,934	4,949	8
9	SNF/PED					9
10	ICF	24,288	23,772		48,060	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,288	23,787	4,934	53,009	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.99%

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)

INDIVIDUAL LIVING UNITS, SENIOR APARTMENTS

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES 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 / /

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

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 19 and days of care provided 4,934

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: / / Fiscal Year: / /

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

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	504,652	40,545	11,581	556,778		556,778	556,778			1
2	Food Purchase		265,379		265,379		265,379	265,379			2
3	Housekeeping	230,483	41,352	177	272,012		272,012	272,012			3
4	Laundry	43,969	1,516	174,285	219,770		219,770	219,770			4
5	Heat and Other Utilities			411,064	411,064		411,064	411,064			5
6	Maintenance	82,404	62,045	59,619	204,068		204,068	(17,015)	187,053		6
7	Other (specify):*										7
8	TOTAL General Services	861,508	410,837	656,726	1,929,071		1,929,071	(17,015)	1,912,056		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	3,256,899	58,851	94,741	3,410,491		3,410,491	3,410,491			10
10a	Therapy			492,222	492,222		492,222	492,222			10a
11	Activities	111,509	8,386	2,266	122,161		122,161	122,161			11
12	Social Services	97,207	77	19,210	116,494		116,494	116,494			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,465,615	67,314	608,439	4,141,368		4,141,368	4,141,368			16
	C. General Administration										
17	Administrative	83,293			83,293		83,293	83,293			17
18	Directors Fees										18
19	Professional Services			64,914	64,914		64,914	(11,503)	53,411		19
20	Dues, Fees, Subscriptions & Promotions			20,494	20,494		20,494	(430)	20,064		20
21	Clerical & General Office Expenses	242,389	12,015	149,601	404,005		404,005	(17,227)	386,778		21
22	Employee Benefits & Payroll Taxes			1,149,137	1,149,137	(3,338)	1,145,799		1,145,799		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,431	4,431		4,431		4,431		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			145,629	145,629		145,629		145,629		26
27	Other (specify):* BAD DEBT			12,338	12,338		12,338	(12,338)			27
28	TOTAL General Administration	325,682	12,015	1,546,544	1,884,241	(3,338)	1,880,903	(41,498)	1,839,405		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,652,805	490,166	2,811,709	7,954,680	(3,338)	7,951,342	(58,513)	7,892,829		29

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

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

Facility Name & ID Number SUNSET HOME

#0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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	
	D. Ownership											
30	Depreciation			570,821	570,821	(132,235)	438,586		438,586			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			247,859	247,859	(119,251)	128,608	(623)	127,985			32
33	Real Estate Taxes			831	831		831		831			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			819,511	819,511	(251,486)	568,025	(623)	567,402			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,368		87,368		87,368		87,368			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,141	95,141		95,141		95,141			42
43	Other (specify):*			428,947	428,947	254,824	683,771	(683,771)				43
44	TOTAL Special Cost Centers		87,368	524,088	611,456	254,824	866,280	(683,771)	182,509			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,652,805	577,534	4,155,308	9,385,647		9,385,647	(742,907)	8,642,740			45

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

Facility Name & ID Number SUNSET HOME

0011643

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Ending: 09/30/09

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,315)	6		5
6	Rented Facility Space	(2,700)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(11,503)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,338)	27		24
25	Fund Raising, Advertising and Promotional	(38,208)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,064)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (79,064)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SUNSET HOME

Report Period Beginning: 10/1/08
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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	CHAMBER OF COMMERCE DUES	\$ (430)	20	1
2	INTEREST ON GIFT ANNUITIES	(623)	32	2
3	VILLA INDEP UNITS	(542,787)	43	3
4	SENIOR APARTMENTS	(102,776)	43	4
5	MARKETING DIRECTOR WAGES	(17,227)	21	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	(663,843)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME# 0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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

	Operating Expenses	PAGES	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	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	(17,015)	0	0	0	0	0	0	0	0	0	0	(17,015)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17,015)	0	(17,015)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,503)	0	0	0	0	0	0	0	0	0	0	(11,503)	19
20	Fees, Subscriptions & Promotions	(430)	0	0	0	0	0	0	0	0	0	0	(430)	20
21	Clerical & General Office Expenses	(17,227)	0	0	0	0	0	0	0	0	0	0	(17,227)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(12,338)	0	0	0	0	0	0	0	0	0	0	(12,338)	27
28	TOTAL General Administration	(41,498)	0	(41,498)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,513)	0	(58,513)	29									

STATE OF ILLINOIS

Facility Name & ID Number SUNSET HOME

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Report Period Beginning:

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Ending:

Summary B

09/30/09

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(623)	0	0	0	0	0	0	0	0	0	0	(623)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(623)	0	0	0	0	0	0	0	0	0	0	(623)	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):*	(683,771)	0	0	0	0	0	0	0	0	0	0	(683,771)	43
44	TOTAL Special Cost Centers	(683,771)	0	0	0	0	0	0	0	0	0	0	(683,771)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(742,907)	0	0	0	0	0	0	0	0	0	0	(742,907)	45

Facility Name & ID Number SUNSET HOME

0011643

Report Period Beginning: 10/1/08

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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

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

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

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

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/08 Ending: 09/30/09

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SUNSET HOME

0011643

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10/1/08

Ending: 09/30/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number SUNSET HOME

0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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	Name of Lender	2		3	4	5	6		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	MERCANTILE		X	RENOVATION 1,2,4	\$16,900.00	12/19/03	\$ 2,150,000	\$ 1,900,201	12/19/28	0.0475	\$ 93,104	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	MERCANTILE		X	LINE OF CREDIT		12/21/08	1,000,000	125,057	12/21/09	0.0550	34,881	6					
7												7					
8												8					
9	TOTAL Facility Related				\$16,900.00		\$ 3,150,000	\$ 2,025,258			\$ 127,985	9					
B. Non-Facility Related*																	
10	MERCANTILE		X	APARTMENTS PERM LOAN	\$13,286.00	12/19/03	2,850,000	2,565,519	12/19/28	0.0475	119,251	10					
11	GIFT ANNUITIES		X	NONE							623	11					
12												12					
13												13					
14	TOTAL Non-Facility Related				\$13,286.00		\$ 2,850,000	\$ 2,565,519			\$ 119,874	14					
15	TOTALS (line 9+line14)						\$ 6,000,000	\$ 4,590,777			\$ 247,859	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.)

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

1. Real Estate Tax accrual used on 2008 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.)		\$	831	2
3. Under or (over) accrual (line 2 minus line 1).		\$	831	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	831	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	344	8	
	2005	502	9	
	2006	1,040	10	
	2007	796	11	
	2008	831	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT KELLEY HATFIELD

TELEPHONE 217-223-2636 EXT 311 FAX #: 217-223-9867

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>23-2-0917-000-00</u>	<u>VACANT LOT</u>	\$ <u>98.24</u>	\$ <u>98.24</u>
2.	<u>23-2-0926-000-00</u>	<u>VACANT LOT</u>	\$ <u>194.44</u>	\$ <u>194.44</u>
3.	<u>23-2-0971-000-00</u>	<u>VACANT LOT</u>	\$ <u>140.54</u>	\$ <u>140.54</u>

Facility Name & ID Number SUNSET HOME

0011643 Report Period Beginning:

10/1/08 Ending:

09/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior BRICK Frame STEEL-FIREPROOF Number of Stories 4

C. Does the Operating Entity? (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).

VILLA APARTMENTS 16 2BEDROOM UNITS 16,000 SQ FT

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>199,487</u>		<u>\$ 102,419</u>	<u>1</u>
2	<u>PARKING LOT ADDITIONAL</u>	<u>15,000</u>	<u>1996-97</u>	<u>86,288</u>	<u>2</u>
3	TOTALS	214,487		\$ 188,707	3

Facility Name & ID Number SUNSET HOME

0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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	34	1958	1958	\$ 354,000	\$	50	\$	\$	\$ 354,000	4
5	71	1971	1971	1,218,562	24,371	50	24,371		926,079	5
6	49	1972	1972	472,577	9,452	50	9,452		356,802	6
7	5	1987	1987	68,497		20			68,497	7
8	43	2001	2001	2,500,281	83,343	30	83,343		666,742	8
Improvement Type**										
9	BUILDING IMPROVEMENTS		1958	12,000		10			12,000	9
10	BUILDING IMPROVEMENTS		1972	51,124	1,023	50	1,023		37,838	10
11	BUILDING IMPROVEMENTS		1977	14,179		20			14,179	11
12	BUILDING IMPROVEMENTS		1978	442,103	8,842	50	8,842		278,639	12
13	BUILDING IMPROVEMENTS		1979	13,639	273	50	273		8,323	13
14	BUILDING IMPROVEMENTS		1980	771		20			771	14
15	BUILDING IMPROVEMENTS		1981	3,742		10			3,742	15
16	BUILDING IMPROVEMENTS		1982	13,900		10			13,900	16
17	BUILDING IMPROVEMENTS		1983	14,951		20			14,951	17
18	BUILDING IMPROVEMENTS		1985	272,013	6,800	40	6,800		165,351	18
19	BUILDING IMPROVEMENTS		1987	321,886		10-20			321,885	19
20	BUILDING IMPROVEMENTS		1988	36,315		10-20			36,315	20
21	BUILDING IMPROVEMENTS		1989	99,114	1,652	10-20	1,652		99,112	21
22	BUILDING IMPROVEMENTS		1990	36,949	928	20	928		34,409	22
23	BUILDING IMPROVEMENTS		1992	11,222	156	10-20	156		10,800	23
24	BUILDING IMPROVEMENTS		1993	31,474	1,151	10-20	1,151		27,005	24
25	BUILDING IMPROVEMENTS		1994	9,466	382	5-20	382		7,748	25
26	BUILDING IMPROVEMENTS		1995	99,649	5,321	5-15	5,321		97,501	26
27	BUILDING IMPROVEMENTS		1996	25,111	1,256	20	1,256		16,505	27
28	BUILDING IMPROVEMENTS		1997	356,451	16,724	5-20	16,724		231,020	28
29	BUILDING IMPROVEMENTS		1998	107,004	5,087	5-20	5,087		63,768	29
30	BUILDING IMPROVEMENTS		1999	1,696	84	10	84		1,696	30
31	BUILDING IMPROVEMENTS		2000	30,811	1,540	20	1,540		13,504	31
32	BUILDING IMPROVEMENTS		2001	24,121	2,230	10-20	2,230		17,745	32
33	BUILDING IMPROVEMENTS		2002	48,990	4,460	10-20	4,460		33,015	33
34	BUILDING IMPROVEMENTS		2004	16,042	1,311	5-20	1,311		6,562	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 SUNSET HOME

0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	RENOVATION 3RD FLOOR SHOWER ROOM	2006	\$ 56,337	\$ 2,817	20	\$ 2,817	\$	\$ 9,859	37
38	RAMPS AND RAILS	2007	2,939	196	15	196		490	38
39	WALLGUARD	2007	5,808	387	15	387		968	39
40	CONCRETE WORK	2007	13,500	900	15	900		2,250	40
41	THE FOLLOWING RENOVATION 1ST,2ND, 4TH FLOOR WEST								41
42	LEANDER CONSTRUCTION	2007	2,188,906	87,556	25	87,556		218,890	42
43	LZT ARCHITECHT	2007	233,722	9,349	25	9,349		23,372	43
44	ATTORNEY FEES CAPITALIZED	2007	52310	2,092	25	2,092		5,231	44
45	IDPH APPROVED PLANS	2007	9600	384	25	384		960	45
46	3 CASCADE BATHING SYATEM	2007	26674	1,067	25	1,067		2,667	46
47	CASCADE SPA	2007	8558	342	25	342		855	47
48	ALARMS COMMUNICATIONS	2007	17577	703	25	703		1,758	48
49	ASBESTOS REMOVAL	2007	43644	1,746	25	1,746		4,365	49
50	ADDITIONAL ARCHITECHT ENGINEERING FEES	2007	51320	2,053	25	2,053		5,132	50
51	DRYWALL	2007	105176	4,207	25	4,207		10,518	51
52	LEANDER CONSTRUCTION	2008	52103	2,084	25	2,084		3,126	52
53	LZT ARCHITECHT	2008	4117	164	25	164		246	53
54	ATTORNEY FEES CAPITALIZED	2008	1588	64	25	64		96	54
55	TOTAL RENOVATION 1ST,2ND,4TH FLOOR \$2,795,295								55
56	DRAPES AND HARDWARE 1,2,4	2007	42,347	4,235	10	4,235		10,587	56
57	COPPER ROOF	2009	10,798	540	10	540		540	57
58	HAND RAILS	2009	11,359	379	15	379		379	58
59									59
60	FIXED EQUIPMENT	1971	814,827		25			814,827	60
61	FIXED EQUIPMENT	1972	253,064		25			253,063	61
62	FIXED EQUIPMENT	1978	280,726		25			280,726	62
63	FIXED EQUIPMENT	1979	13,938		10			13,938	63
64	FIXED EQUIPMENT	1984	23,531		10			23,531	64
65	FIXED EQUIPMENT	1985	117,689		5-20			117,687	65
66	FIXED EQUIPMENT	1986	13,909		10-15			13,908	66
67	FIXED EQUIPMENT	1987	12,320		10-20			12,320	67
68	FIXED EQUIPMENT	1988	8,162		10-20			8,162	68
69	FIXED EQUIPMENT	1989	4,670		15			4,670	69
70	TOTAL (lines 4 thru 69)		\$ 11,189,859	\$ 297,651		\$ 297,651	\$	\$ 5,785,525	70

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

Facility Name & ID Number SUNSET HOME

0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,189,859	\$ 297,651		\$ 297,651	\$	\$ 5,785,525	1
2	FIXED EQUIPMENT	1993	259,307	11,891	10-20	11,891		215,708	2
3	FIXED EQUIPMENT	1995	188,017	9,549	10-20	9,549		136,732	3
4	FIXED EQUIPMENT	1996	10,809	88	10-15	88		10,678	4
5	FIXED EQUIPMENT	1997	35,461	1,812	15-20	1,812		22,339	5
6	FIXED EQUIPMENT	1998	173,001	8,865	15-20	8,865		101,866	6
7	FIXED EQUIPMENT	1999	8,744	526	15-20	526		5,169	7
8	FIXED EQUIPMENT	2000	272,461	14,155	10-20	14,155		130,336	8
9	FIXED EQUIPMENT	2001	40,619	2,424	10-20	2,424		19,121	9
10	FIXED EQUIPMENT	2002	81,604	5,504	10-20	5,504		38,914	10
11	FIXED EQUIPMENT	2003	105,075	6,172	15-20	6,172		38,038	11
12	FIXED EQUIPMENT	2004	142,116	8,970	15-25	8,970		44,448	12
13	FIXED EQUIPMENT	2005	51,320	3,262	10-25	3,262		19,369	13
14	SUPRESSION SYSTEM MAIN KITCHEN	2007	4,827	193	25	193		483	14
15	OUTDOOR EMERGENCY LIGHTING	2007	9,680	645	15	645		1,614	15
16	CHILLER REPLACEMENT	2008	24,923	1,662	15	1,662		2,493	16
17	30 CONCENTRATORS	2009	12,443	415	15	415		415	17
18	SMOKE DETECTORS	2009	2,803	93	15	93		93	18
19	GENERATOR TRANSFER SWITCH	2009	3,000	75	20	75		75	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,616,069	\$ 373,952		\$ 373,952	\$	\$ 6,573,416	34

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

Facility Name & ID Number SUNSET HOME

0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward								
2	LAND IMPROVEMENTS	1975	\$ 2,807		25			\$ 2,807	2
3	LAND IMPROVEMENTS	1978	495		10			495	3
4	LAND IMPROVEMENTS	1979	6,425		10			6,425	4
5	LAND IMPROVEMENTS	1992	56,865		10			56,865	5
6	LAND IMPROVEMENTS	1995	18,601		12			18,601	6
7	LAND IMPROVEMENTS	1997	4,800	192	25	192		2,400	7
8	LAND IMPROVEMENTS	1999	44,219	3,685	12	3,685		38,693	8
9	LAND IMPROVEMENTS	2000	17,559	707	10-25	707		13,463	9
10	LAND IMPROVEMENTS	2001	1,952	195	10	195		1,658	10
11	LAND IMPROVEMENTS	2003	8,404	560	15	560		3,640	11
12	LAND IMPROVEMENTS	2004	3,450	230	15	230		1,265	12
13	SEEDING AND IMPROVEMENT LOT S 4TH	2006	20,477	2,048	10	2,048		7,168	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,802,123	\$ 381,569		\$ 381,569	\$	\$ 6,726,896	34

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

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	\$ 598,953	\$ 50,721	\$ 50,721	\$		\$ 341,191	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	333,994					333,994	73
74								74
75	TOTALS	\$ 932,947	\$ 50,721	\$ 50,721	\$		\$ 675,185	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	MAINTENANCE	97 3/4 TON GMC & PLOW	1997	\$ 23,521	\$	\$	\$		\$ 23,521	76
77	RESIDENT TRANSPORT	2001 E-450 FORD BUS	2001	56,836					56,836	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216					36,216	78
79	RESIDENT TRANSPORT	2005 TRANSPORT BUS	2005	50,391	6,298	6,298		4	50,391	79
80	TOTALS			\$ 166,964	\$ 6,298	\$ 6,298	\$		\$ 166,964	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)	\$ 14,090,741	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 438,588	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 438,588	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,569,045	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VILLA INDEP UNITS	\$ 1,746,093	\$ 50,011	\$ 905,723	86
87	SUNSET APARTMENTS	2,800,183	82,224	485,405	87
88					88
89					89
90					90
91	TOTALS	\$ 4,546,276	\$ 132,235	\$ 1,391,128	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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><u>COMMUNITY COLLEGE TRAINS AIDES</u></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$			\$ 160,016	\$		\$ 160,016	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs				35,547			35,547	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-3	hrs				209,290			209,290	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 prescrpts					87,368		87,368	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$			\$ 404,853	\$ 87,368		\$ 492,221	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 **SUNSET HOME**# **0011643**Report Period Beginning: **10/1/08**

Ending:

09/30/09**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **09/30/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 78,183	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	999,038		3
4	Supply Inventory (priced at COST)	23,310		4
5	Short-Term Investments			5
6	Prepaid Insurance	87,432		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)	\$ 1,187,963	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,707		13
14	Buildings, at Historical Cost	12,802,117		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,099,909		16
17	Accumulated Depreciation (book methods)	(7,569,047)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,465,314		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LIST ATTACHED	5,223,340		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,210,340	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,398,303	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 327,162	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	469,166		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,780		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SUNSET APARTMENTS	77,871		36
37	HEALTH CLAIMS PAYABLE	108,464		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 987,443	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,025,258		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	N/P SUNSET APARTMENTS	2,565,519		43
44	REF FEES DEFERRED REVENUE	28,626		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,619,403	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,606,846	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,791,457	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,398,303	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,513,670	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,513,670	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,277,787	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,277,787	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)	\$ 9,791,457	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	\$ 9,889,841	1
2	Discounts and Allowances for all Levels	(1,224,864)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,664,977	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,700	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)	\$ 2,700	23
D. Non-Operating Revenue			
24	Contributions	719,691	24
25	Interest and Other Investment Income***	87,758	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 807,449	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	CHANGE IN VALUE SPLIT-INTEREST AGREEMENT	310,226	28
28a	LIST ATTACHED	878,082	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,188,308	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,663,434	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,929,071	31
32	Health Care	4,141,368	32
33	General Administration	1,884,241	33
B. Capital Expense			
34	Ownership	819,511	34
C. Ancillary Expense			
35	Special Cost Centers	87,368	35
36	Provider Participation Fee	95,141	36
D. Other Expenses (specify):			
37	<u>FUND DEVELOPMENT</u>	34,870	37
38	<u>SUNSET APARTMENTS</u>	341,312	38
39	<u>VILLA</u>	52,765	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,385,647	40
41	Income before Income Taxes (line 30 minus line 40)**	1,277,787	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,277,787	43

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

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

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

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

Facility Name & ID Number **SUNSET HOME**

0011643

Report Period Beginning:

10/1/08

Ending:

09/30/09

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	1,990	2,086	\$ 58,893	\$ 28.23	1
2	Assistant Director of Nursing	1,942	2,038	48,511	23.80	2
3	Registered Nurses	18,983	20,615	415,484	20.15	3
4	Licensed Practical Nurses	65,710	71,572	1,132,836	15.83	4
5	CNAs & Orderlies	136,633	147,005	1,539,659	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,938	2,086	23,637	11.33	9
10	Activity Assistants	9,111	9,925	87,872	8.85	10
11	Social Service Workers	5,255	5,639	69,346	12.30	11
12	Dietician					12
13	Food Service Supervisor	3,328	3,570	56,512	15.83	13
14	Head Cook	633	703	11,077	15.76	14
15	Cook Helpers/Assistants	38,805	42,217	393,036	9.31	15
16	Dishwashers	3,878	4,205	44,027	10.47	16
17	Maintenance Workers	5,977	6,328	82,364	13.02	17
18	Housekeepers	21,551	23,626	204,814	8.67	18
19	Laundry	3,770	4,168	43,969	10.55	19
20	Administrator	1,971	2,165	83,293	38.47	20
21	Assistant Administrator					21
22	Other Administrative	5,859	6,257	119,810	19.15	22
23	Office Manager					23
24	Clerical	7,674	8,435	104,977	12.45	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	966	1,046	18,938	18.11	31
32	Other Health Care(specify)	4,480	4,751	52,664	11.08	32
33	Other(specify)	5,282	5,602	61,086	10.90	33
34	TOTAL (lines 1 - 33)	345,736	374,039	\$ 4,652,805 *	\$ 12.44	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	\$ 11,228	1-3	35
36	Medical Director	3,600	10-3	36
37	Medical Records Consultant	600	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,891	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	801	11-3	44
45	Social Service Consultant	3,709	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,829		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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number SUNSET HOME

0011643

Report Period Beginning: 10/1/08

Ending: 09/30/09

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? YES
If YES, give association name and amount. LIFE SERVICE NETWORKS 9,495
- (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? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,194 Line 10-2
- (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. \$ 95,141
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? _____ 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. \$ 300,000
- (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? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: GRAY HUNTER STENN LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SUNSET HOME

#0011643

10/01/08-9/30/09

XVIII STAFFING & SALARY COSTS

	<u>1</u> # OF HRS. ACTUALLY WORKED	<u>2</u> # OF HRS. PAID AND ACCRUED	<u>3</u> TOTAL SALARIES AND WAGES	<u>4</u> AVERAGE HOURLY WAGE
<u>LINE 32 - OTHER</u>				
NRS-SUPPLY COORDINATOR	0	0	0	
NRS- TRANSPORTER	2,079	2,158	19,196	8.90
SOC SERV- DIRECTOR	1,938	2,085	27,861	13.36
NRS- CLERICAL	463	508	5,607	11.04
	<u>4,480</u>	<u>4,751</u>	<u>52,664</u>	
 <u>LINE 33 - OTHER</u>				
MARKETING DIRECTOR	1,312	1,362	17,227	12.65
HOUSEKEEPING DIRECTOR	2,037	2,166	25,669	11.85
SUPPLY COORDINATOR	1,933	2,074	18,190	8.77
	<u>5,282</u>	<u>5,602</u>	<u>61,086</u>	

SUNSET HOME #0011643
BALANCE SHEET- SCH XV
SEPTEMBER 30, 2009

OPERATING

LINE 23-OTHER

VILLA BUILDING & EQUIPMENT NET OF DEPRECIATION (905,723)	840,368
SUNSET APARTMENTS LAND, BUILDING & EQUIPMENT NET OF DEPRECIATION (485,405)	2,764,778
UNAMORTIZED BOND COSTS	81,811
ASSETS INTERNALLY (BOARD) DESIGNATED	136,354
ADDITIONAL LAND COSTS	395,311
LAND HELD FOR EXPANSION	1,004,718
	<u>5,223,340</u>

An interest income offset is not applicable at 9/30/09 because of the following reasons.

- 1) There has been a loss from operations for the last twenty-four years. So no additional monies have been generated from operations for investment purposes.
- 2) The majority of investments are derived from contributions and endowments.

SUNSET HOME
#0011643
10/01/08-9/30/09

XVII INCOME STATEMENT LINE 28 OTHER REVENUE

VILLA INDEPENDENT LIVING	159,671
SUNSET APARTMENTS RENTAL FEES	700,281
MISCELLANEOUS INCOME	18,130
	<u>878,082</u>

SUNSET HOME

#0011643

10/01/08-9/30/09

XIX SUPPORT SCHEDULE C. PROFESSIONAL SERVICES

	<u>AMOUNT</u>	<u>INVOICES ATTACHED</u>
SCHOLZ LOOS PALMER SIEBERS LEGAL	46.00	X
	118.87	x
	759.00	x
	126.50	x
	322.00	x
	418.50	x
	1,221.75	x
	634.50	x
	1,034.00	x
	526.50	x
	890.00	x
	216.00	x
	297.00	x
	378.00	x
	108.00	x
	745.00	x
	337.50	x
	46.00	x
	192.00	x
	724.50	x
	448.50	x
	149.50	x
	1,334.00	x
	94.50	x
	418.50	x
	297.00	x
	1,377.00	x
	13,260.62	

SUNSET HOME #0011643
 COST CENTER SCH V
 10/01/08-9/30/09

	SALARY 1	SUPPLIES 2	OTHER 3	TOTAL 4	RECLASS 5	RECLASS TOTAL 6	ADJUST 7	ADJUSTED TOTAL 8
LINE 43-OTHER								
FUND DEVELOP.			34,870	34,870	3,338	38,208	(38,208)	0
SUNSET APARTMENTS			341,312	341,312	201,475	542,787	(542,787)	0
VILLA			52,765	52,765	50,011	102,776	(102,776)	0
	<u>0</u>	<u>0</u>	<u>428,947</u>	<u>428,947</u>	<u>254,824</u>	<u>683,771</u>	<u>(683,771)</u>	<u>0</u>

SCHEDULE V LINE 23 IN-SERVICE TRAINING & EDUCATION SUNSET HOME #0011643 10-1-08/ 9-30-09 PA COST REPORT

Start Date	End Date	Who Attended	Title	Where	Seminar Name/Sponsor	Cost
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SCHEDULE V LINE 24 TRAVEL & SEMINAR SUNSET HOME #0011643 10-1-08/ 9-30-09 PA COST REPORT

Start Date	End Date	Who Attended	Title	Where	Seminar Name/Sponsor	Cost
10/8/2008	10/8/2008	Lori Raleigh	Dietary Asst	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
10/8/2008	10/8/2008	Mary Jane Dale	Dietary Dir	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
10/8/2008	10/8/2008	Judy Morse	Dietary	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
10/8/2008	10/8/2008	Terry Clifford	Dietary	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
10/8/2008	10/8/2008	Brittany Galbraith	Dietary	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
10/8/2008	10/8/2008	Ashley Mason	Dietary	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
10/8/2008	10/8/2008	Debbie Marshall	Dietary	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
10/8/2008	10/8/2008	Theresa Hoffman	Dietary	Quincy, IL	Kohl Wholesale Food Show	\$0.00 (free)
#####	#####	Mary Jane Dale	Dietary Dir	Waterloo, IA	Martin Bros Food Show	\$0.00 (free)
#####	#####	Lori Raleigh	Dietary Asst	Waterloo, IA	Martin Bros Food Show	\$0.00 (free)
#####	#####	Theresa Taylor	Haven Coord	Springfield, IL	Hotel stay for 1 night - for free Alzheimer's seminar	\$55.99
#####	#####	Jeni Yaeger	Social Ser Dir	Springfield, IL	Attend an LSN Seminar on Enhance Your Frontline	\$150.00
#####	#####	Christine Hopson	Administrator	Quincy, IL	Attend Celebrate Aging Seminar	\$55.00 (CEU's)
#####	#####	Jody James	DON	Quincy, IL	Attend Celebrate Aging Seminar	\$40.00
#####	#####	Marsha Riney	ADON	Quincy, IL	Attend Celebrate Aging Seminar	\$40.00
#####	#####	Nikki Neese	Activity Dir	Quincy, IL	Attend Celebrate Aging Seminar	\$55.00 (CEU's)
#####	#####	Mercedes Thompson	Activity Aid	Quincy, IL	Attend Celebrate Aging Seminar	\$55.00 (CEU's)
#####	#####	Rhonda Hummel	Activity Aid	Quincy, IL	Attend Celebrate Aging Seminar	\$55.00 (CEU's)
#####	#####	Barb Dietrich	Fund Dev Dir	Quincy, IL	Attend Celebrate Aging Seminar	\$0.00 (free)
1/8/2009	1/8/2009	Tamra Cowen	Marketing Dir	Quincy, IL	Attend a free Alzheimer's Breakfast at Qcy Sr. Cente	\$0.00 (free)
1/9/2009	1/9/2009	Barb Dietrich	Fund Dev Dir	Quincy, IL	Attend a Grant writing workshop	\$50.00
9/6/2008	9/6/2008	Barb Dietrich	Fund Dev Dir	Peoria, IL	Mileage Reimbursement	\$176.54
1/28/2009	1/28/2009	Lori Raleigh	Dietary	Quincy, IL	Kohl's Sanitation Refresher Course	\$0.00 (free)
1/28/2009	1/28/2009	Debbie Marshall	Dietary	Quincy, IL	Kohl's Sanitation Refresher Course	\$0.00 (free)
1/28/2009	1/28/2009	Terry Clifford	Dietary	Quincy, IL	Kohl's Sanitation Refresher Course	\$0.00 (free)
1/9/2009	1/30/2009	Tamra Cowen	Marketing Dir	Quincy, IL	Mileage Reimbursement	\$101.99
7/3/2008	#####	Mary Jane Dale	Dietary Dir	IL & IA	Mileage Reimbursement to Macomb, Sprngfld & IA	\$330.78
3/13/2009	3/13/2009	Tamra Cowen	Marketing Dir	Springfield, IL	Mileage Reimbursement to Golden Cross Meeting	\$72.03
1/20/2009	2/4/2009	Nikki Neese	Activity Dir	Quincy, IL	Mileage Reimbursement for Res Shopping 2 mos	\$27.30
4/24/2009	4/24/2009	Nicole Bruns	Nursing	Quincy, IL	C.N.A. Nominee - free	\$0.00 (free)
4/24/2009	4/24/2009	Randy Bruns	Guest	Quincy, IL	C.N.A. Nominee guest	\$0.00 (free)
4/24/2009	4/24/2009	Ellen Bruns	Guest	Quincy, IL	C.N.A. Nominee guest	\$7.00
4/24/2009	4/24/2009	Christine Hopson	Administrator	Quincy, IL	C.N.A. Nominee guest	\$7.00
4/24/2009	4/24/2009	Jody James	DON	Quincy, IL	C.N.A. Nominee guest	\$7.00
4/24/2009	4/24/2009	Marsha Riney	ADON	Quincy, IL	C.N.A. Nominee guest	\$7.00
4/24/2009	4/24/2009	Robyn Johnson	Unit Coord	Quincy, IL	C.N.A. Nominee guest	\$7.00
4/24/2009	4/24/2009	Theresa Taylor	Unit Coord	Quincy, IL	C.N.A. Nominee guest	\$7.00
5/8/2009	5/8/2009	Tamra Cowen	Marketing Dir	Quincy, IL	Booth rental for Bridge the Gap to health Expo	\$75.00
5/12/2009	5/12/2009	Jessie Vahle	Nursing	Quincy, IL	Managing the Treatment of Over Active Bladder in L	\$0.00 (free)
5/12/2009	5/12/2009	Laura Yeakey	Nursing	Quincy, IL	Managing the Treatment of Over Active Bladder in L	\$0.00 (free)
5/12/2009	5/12/2009	Rhonda Warning	Nursing	Quincy, IL	Managing the Treatment of Over Active Bladder in L	\$0.00 (free)

5/12/2009	5/12/2009	Deb Hickman	Nursing	Quincy, IL	Managing the Treatment of Over Active Bladder in L	\$0.00	(free)
5/12/2009	5/12/2009	Linda Prather	MDS Coord	Quincy, IL	Managing the Treatment of Over Active Bladder in L	\$0.00	(free)
5/22/2009	5/22/2009	Jeni Yaeger	Social Ser Dir	Quincy, IL	Dimensions of Dementia - Alzheimer's Association	\$0.00	(free)
5/22/2009	5/22/2009	Jackie Carlson	Social Service	Quincy, IL	Dimensions of Dementia - Alzheimer's Association	\$0.00	(free)
6/10/2009	6/25/2009	Tasha Rothweiler	Act. Asst Dir	Springfield, IL	36 Hr Act Dir Course - 2 days each time/3 times tota	\$360.00	
5/29/2009	5/29/2009	Christine Hopson	Administrator	Quincy, IL	Fingerprint Background Ck Rules - LSN/AASHA Tele	\$0.00	(free)
6/4/2009	6/4/2009	Tamra Cowen	Marketing Dir	Peoria, IL	Hotel expense for 1 night for Golden Cross Conf	\$75.71	
8/5/2009	8/6/2009	Christine Hopson	Administrator	Bloomington, IL	Attend IL Nursing Home Administrators Assoc Conf	\$195.00	
8/5/2009	8/6/2009	Kelley Hatfield	Accounting Dir	Bloomington, IL	Attend IL Nursing Home Administrators Assoc Conf	\$195.00	
7/31/2009	8/29/2009	Tasha Rothweiler	Act. Asst Dir	East Peoria, IL	36 Hr Act Dir Course - 2 days each time/2 times tota	\$500.00	
6/10/2009	6/25/2009	Tasha Rothweiler	Act. Asst Dir	Springfield, IL	Refund for 36Hr Act. Dir course -2 days ea/3times tc	(\$360.00)	
4/8/2009	6/3/2009	Nikki Neese	Activity Dir	Quincy, IL	Mileage reimbursement for Res. Shopping 3 mos	\$15.30	
8/11/2009	8/11/2009	Linda Prather	MDS Coord	Springfield, IL	HFS MDS Medicaid Audit Results	\$95.00	
8/11/2009	8/11/2009	Rita Schulze	Restorative	Springfield, IL	HFS MDS Medicaid Audit Results	\$95.00	
8/11/2009	8/11/2009	Lisa McDonald	Restorative	Springfield, IL	HFS MDS Medicaid Audit Results	\$95.00	
9/14/2009	9/17/2009	Christine Hopson	Administrator	Peoria, IL	Attend IHCA Convention	\$1,295.00	Group Rate
9/14/2009	9/17/2009	Kelley Hatfield	Accounting Dir	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Jeni Yaeger	Social Service	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Jody James	DON	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Marsha Riney	ADON	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Nikki Neese	Act. Dir	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Theresa Taylor	Unit Coord	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Pam Fessler	Res Accts	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Lori Raleigh	Dietary Supv	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Mike Davis	Dietary Supv	Peoria, IL	Attend IHCA Convention		
9/14/2009	9/17/2009	Mercedes Thompson	Activity Aid	Peoria, IL	Attend IHCA Convention		
9/15/2009	9/15/2009	Jeni Yaeger	Social Service	Peoria, IL	Mileage Reimbursement for IHCA Convention	\$106.13	
9/15/2009	9/15/2009	Lori Raleigh	Dietary Supv	Peoria, IL	Mileage Reimbursement for IHCA Convention	\$106.55	
9/16/2009	9/16/2009	Nikki Neese	Activity Dir	Peoria, IL	Mileage Reimbursement for IHCA Convention	\$104.51	
9/15/2009	9/15/2009	Pam Fessler	Res's Accts	Peoria, IL	Mileage Reimbursement for IHCA Convention	\$74.84	
8/29/2009	8/30/2009	Tasha Rothweiler	Act Asst	East Peoria, IL	Mileage Reimbursement for 36 Hr Activity Course	\$96.00	
						<u>\$4,430.67</u>	