

Facility Name & ID Number Sunset Rehabilitation & Hlth C

0046094 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	25	Skilled (SNF)	25	9,125	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	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			1,805	1,805	8
9	SNF/PED					9
10	ICF	23,747	5,082	647	29,476	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,747	5,082	2,452	31,281	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.52%

D. How many bed-hold days during this year were paid by the Department? None (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 Non-allowable costs have been eliminated in Schedule V, Column 7

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 08/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/01/90 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 25 and days of care provided 1,805

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

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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	152,519	18,118		170,637		170,637	5,470	176,107		1
2	Food Purchase		189,270		189,270		189,270	(43,322)	145,948		2
3	Housekeeping	191,108	26,432		217,540		217,540	51	217,591		3
4	Laundry	22,697	14,430		37,127		37,127		37,127		4
5	Heat and Other Utilities			117,428	117,428		117,428	540	117,968		5
6	Maintenance	47,265	14,243	33,579	95,087		95,087	2,650	97,737		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							988	988		7
8	TOTAL General Services	413,589	262,493	151,007	827,089		827,089	(33,623)	793,466		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,263,246	73,416	2,172	1,338,834		1,338,834	3,261	1,342,095		10
10a	Therapy		107	378,229	378,336		378,336		378,336		10a
11	Activities	37,269	1,124	2,119	40,512		40,512		40,512		11
12	Social Services	29,473			29,473		29,473		29,473		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							408	408		15
16	TOTAL Health Care and Programs	1,329,988	74,647	400,520	1,805,155		1,805,155	3,669	1,808,824		16
	C. General Administration										
17	Administrative	14,000			14,000		14,000	47,889	61,889		17
18	Directors Fees										18
19	Professional Services			5,240	5,240		5,240	7,670	12,910		19
20	Dues, Fees, Subscriptions & Promotions			4,590	4,590		4,590	1,160	5,750		20
21	Clerical & General Office Expenses	18,473	6,217	5,864	30,554		30,554	55,285	85,839		21
22	Employee Benefits & Payroll Taxes			494,157	494,157		494,157		494,157		22
23	Inservice Training & Education							569	569		23
24	Travel and Seminar							176	176		24
25	Other Admin. Staff Transportation			6,626	6,626		6,626	2,749	9,375		25
26	Insurance-Prop.Liab.Malpractice			38,982	38,982		38,982	1,140	40,122		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							14,973	14,973		27
28	TOTAL General Administration	32,473	6,217	555,459	594,149		594,149	131,611	725,760		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,776,050	343,357	1,106,986	3,226,393		3,226,393	101,657	3,328,050		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.

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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			107,670	107,670		107,670	42,517	150,187			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			220,702	220,702		220,702	1,903	222,605			32
33	Real Estate Taxes			32,801	32,801		32,801	693	33,494			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,555	11,555		11,555	663	12,218			35
36	Other (specify):*											36
37	TOTAL Ownership			372,728	372,728		372,728	45,776	418,504			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,286		53,286		53,286		53,286			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):* Non-allowable Cost	12,000	739	115,524	128,263		128,263	(128,263)				43
44	TOTAL Special Cost Centers	12,000	54,025	178,487	244,512		244,512	(128,263)	116,249			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,788,050	397,382	1,658,201	3,843,633		3,843,633	19,170	3,862,803			45

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

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (2,023)	43	1
2	X-Rays-Part A	(363)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(50)	10	3
4	Resident Flowers	(1,180)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(495)	21	5
6	Nonallowable Dues	(977)	20	6
7	Offset Meals on Wheels Revenue	(39,950)	2	7
8	Disallowed Special Events	(1,512)	43	8
9	Offset Interest Paid on Medicare Withholding	(1,710)	32	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	(48,260)		49

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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
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,470	\$ 5,470	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	123	123	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	51	51	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	540	540	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,650	2,650	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	988	988	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,311	3,311	8	
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	408	408	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	47,889	47,889	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,670	7,670	12	
13	V							13	
14	Total		\$			\$ 69,100	\$ *	69,100	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 2,137	\$ 2,137
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	55,780	55,780
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	569	569
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	176	176
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,749	2,749
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,140	1,140
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	14,973	14,973
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,509	4,509
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,934	6,934
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	693	693
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0	
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	663	663
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 90,323	\$ * 90,323

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

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1/1/2009

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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	Mark Petersen	President	Administrative	100.00	155,557	1.22	2.03	Salary	\$ 3,556	L17, C7	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	\$ 3,556		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

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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

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	31,281	\$ 5,470	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	31,281	123	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	31,281	51	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	31,281	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	31,281	540	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	31,281	2,650	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	31,281	988	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	31,281	3,311	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	31,281	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	31,281	408	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	31,281	47,889	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	31,281	7,670	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	31,281	2,137	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	31,281	55,780	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	31,281	569	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	31,281	176	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	31,281	2,749	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	31,281	1,140	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	31,281	14,973	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	31,281	4,509	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	31,281	6,934	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	31,281	693	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	31,281	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	31,281	663	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 159,423	25

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Mortgage	Varies	08/31/02	\$ 4,050,000	\$ 3,890,514	12/31/13	Varies	\$ 218,992	1								
2												2								
3							Interest Income Offset				(3,321)	3								
4							Home Office Allocation-PHC				6,934	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 4,050,000	\$ 3,890,514			\$ 222,605	9								
B. Non-Facility Related*																				
10							Interest Paid on Medicare Withholding				1,710	10								
11							Interest Offset on Medicare Withholding Interest Paid				(1,710)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 4,050,000	\$ 3,890,514			\$ 222,605	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,798 B. General Construction Type: Exterior Brick Frame 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).

N/A

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>41,382</u>	<u>2002</u>	<u>\$ 95,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	41,382		\$ 95,000	3

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	105	2002	1972	\$ 2,315,000	\$	30	\$ 77,167	\$ 77,167	\$ 578,752	4
5			2001	413,768		20	20,688	20,688	175,848	5
6	2		2003	148,271		20	7,414	7,414	48,191	6
7	8		2005	355,587		39	9,118	9,118	41,031	7
8										8
	Improvement Type**									
9	Petersen Properties Building Partnership		1990	6,417		15			6,417	9
10	Petersen Properties Building Partnership		1991	10,127		15			10,127	10
11	Petersen Properties Building Partnership		1993	4,719		15			4,719	11
12	Petersen Properties Building Partnership		1994	1,780		15	35	35	1,780	12
13	Petersen Properties Building Partnership		1995	13,199		20	660	660	9,726	13
14										14
15	Field Audit		1990	1,102		15			1,102	15
16	Drapes		1995	8,206		20	410	410	5,877	16
17	Remodeling		1996	14,630		20	732	732	9,640	17
18	Awning		1996	1,105		20	55	55	720	18
19	Landscaping		1996	4,036		20	202	202	2,761	19
20	Back Taxes on Land		1996	531		20	27	27	317	20
21	Tiling		1997	500		20	25	25	300	21
22	Doors		1997	5,250		20	263	263	3,419	22
23	Tiling		1997	8,228		20	411	411	5,309	23
24	Gutters		1997	2,759		20	138	138	1,760	24
25	Landscaping		1997	1,886		20	94	94	1,199	25
26	Door Closer		1997	1,688		20	84	84	1,036	26
27	Concrete Slab		1997	1,440		20	72	72	912	27
28	Painting		1997	1,207		20	60	60	765	28
29	Furnace		1997	2,389		20	119	119	1,448	29
30	Awning		1997	4,077		20	204	204	2,550	30
31	Telephone System		1997	1,189		20	59	59	723	31
32	Roof/Windows		1998	36,145		20	1,807	1,807	20,781	32
33	Drapery		1998	1,402		20	70	70	805	33
34	Expansion Design		1998	3,639		20	182	182	2,093	34
35	Flooring/Cove Base		1998	619		20	31	31	357	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 Rehabilitation & Hlth C# 0046094

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**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	Awnings	1999	\$ 353	\$	20	\$ 18	\$ 18	\$ 189	37
38	Roof (Balance)	1999	1,000		20	50	50	525	38
39	Drapes	2000	1,966		20	98	98	931	39
40	Remove Trees	2000	1,072		20	54	54	513	40
41	Expansion	2000	1,945		20	97	97	926	41
42	Wood	2000	1,072		20	54	54	513	42
43	Land Work	2000	2,510		20	126	126	1,197	43
44	Flooring	2000	1,168		20	58	58	551	44
45	Shades	2001	1,788		20	89	89	757	45
46	Painting	2001	2,228		20	111	111	944	46
47	Carpet	2001	4,841		20	242	242	2,057	47
48	Carpet	2001	8,000		20	400	400	3,400	48
49	Painting	2001	345		20	17	17	145	49
50	Fire System	2001	42,286		20	2,114	2,114	17,969	50
51	Carpet	2001	2,155		20	108	108	918	51
52	Kitchen Remodeling	2001	43,315		20	2,166	2,166	18,411	52
53	Expansion	2002	7,352		20	368	368	2,762	53
54	Wall	2002	6,000		20	300	300	2,250	54
55	New Addition	2004	3,021		20	151	151	832	55
56	Stairway, sunroom, new addition	2004	218,275		20	10,914	10,914	60,027	56
57	Engineering Fees	2005	2,047		20	102	102	459	57
58	IDPH Planning Fee	2005	2,976		20	149	149	670	58
59	Architect Fees	2005	1,904		20	98	98	437	59
60	Asphalt West Lot	2006	21,480		20	1,074	1,074	3,938	60
61	Air Conditioner	2007	3,000		10	300	300	750	61
62	Wheelchair Ramp	2007	930		15	62	62	155	62
63	Fencing	2008	3,634		39	94	94	141	63
64	Generator Repair	2009	3,214		7	230	230	230	64
65	Boiler and Mixing Valve Repair	2009	5,449		7	389	389	389	65
66	Boiler Repair	2009	2,582		7	184	184	184	66
67	Air Conditioner-Dining Room	2009	3,834		7	274	274	274	67
68	Roof Installation	2009	6,752		15	225	225	225	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,779,390	\$		\$ 140,843	\$ 140,843	\$ 1,064,134	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,779,390	\$		\$ 140,843	\$ 140,843	\$ 1,064,134	1
2	Sunroom	2009	10,779		35	154	154	154	2
3									3
4									4
5									5
6	Land Improvements Booked			419			(419)		6
7	Building Booked			59,359			(59,359)		7
8	Building Improvements Booked			40,128			(40,128)		8
9									9
10									10
11									11
12	2008-Home Office Allocation-Land Improvements		1,029			65	65		12
13	2008-Home Office Allocation-Building Improvements		15,378			369	369		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)		\$ 3,806,576	\$ 99,906		\$ 141,431	\$ 41,525	\$ 1,064,288	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	\$ 376,739	\$ 5,075	\$ 4,129	\$ (946)	7-10 yrs.	\$ 368,804	71
72	Current Year Purchases	2,360		118	118	10 yrs.	118	72
73	Fully Depreciated Assets	165,723					165,723	73
74	Home Office Allocation			4,509	4,509			74
75	TOTALS	\$ 544,822	\$ 5,075	\$ 8,756	\$ 3,681		\$ 534,645	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	Facility	1990 Dodge Intrepid	1994	\$ 32,448	\$ 2,689	\$	\$ (2,689)		\$ 32,448	76
77	Facility	1997 Ford E350 Van	1997	41,836					41,836	77
78	Facility	2001 Dodge Caravan	2001	47,863					47,863	78
79	Facility	2001 Chevy	2002	17,143					17,143	79
80	TOTALS			\$ 139,290	\$ 2,689	\$	\$ (2,689)		\$ 139,290	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 4,585,688	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,670	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,187	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 42,517	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,738,223	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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: \$ 5,280 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	\$ 578	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	21

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 \$ _____

* 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.

Sunset Rehabilitation & Hlth C
0046094

Period Beginning **1/1/2009**
Period End **12/31/2009**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	-
Copier		4,617
Home Office Allocation		663
		<u>5,280</u>

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. 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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	11,400	\$ 171,004	\$	11,400	\$ 171,004	1
2	Licensed Speech and Language Development Therapist	10A(2), 10A(3)	hrs		1,127	16,912	7	1,127	16,919	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		12,688	190,313	100	12,688	190,413	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				53,286		53,286	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			\$	25,215	\$ 378,229	\$ 53,393	25,215	\$ 431,622	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 Rehabilitation & Hlth C# 0046094Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 2,920,630	\$ 2,920,630	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	538,922	538,922	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,317	58,317	6
7	Other Prepaid Expenses	15,021	15,021	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,532,890	\$ 3,532,890	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		95,000	13
14	Buildings, at Historical Cost	2,873,789	3,248,004	14
15	Leasehold Improvements, at Historical Cost	997,122	558,572	15
16	Equipment, at Historical Cost	700,232	684,112	16
17	Accumulated Depreciation (book methods)	(1,377,171)	(1,738,223)	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): <u>Goodwill</u>	1,790,000	1,790,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,983,972	\$ 4,637,465	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,516,862	\$ 8,170,355	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 495,023	\$ 495,023	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,086	115,086	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,490	2,490	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,900	33,900	32
33	Accrued Interest Payable	19,888	19,888	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	97,090	97,090	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 763,477	\$ 763,477	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,890,514	3,890,514	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)	\$ 3,890,514	\$ 3,890,514	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,653,991	\$ 4,653,991	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,862,871	\$ 3,516,364	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,516,862	\$ 8,170,355	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,759,105	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4	2008 Bad Debt Allowance Entered After CR Completion	(25,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,734,103	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	128,768	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)	\$ 128,768	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)	\$ 3,862,871	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Sunset Rehabilitation & Hlth C**# **0046094**Report Period Beginning: **1/1/2009**Ending: **12/31/2009**

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	\$ 3,322,578	1
2	Discounts and Allowances for all Levels	(19,241)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,303,337	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	514,972	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 514,972	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	3,495	14
15	Telephone, Television and Radio	370	15
16	Rental of Facility Space		16
17	Sale of Drugs	95,831	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,826	20
21	Other Medical Services	6,754	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 110,276	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,321	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,321	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	545	28
28a	Meals on Wheels Revenue	39,950	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 40,495	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,972,401	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	827,089	31
32	Health Care	1,805,155	32
33	General Administration	594,149	33
B. Capital Expense			
34	Ownership	372,728	34
C. Ancillary Expense			
35	Special Cost Centers	181,549	35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,843,633	40
41	Income before Income Taxes (line 30 minus line 40)**	128,768	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 128,768	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. Facility is part of larger entity.

*** 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 Rehabilitation & Hlth C**

0046094

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	1,573	1,573	\$ 40,891	\$ 26.00	1
2	Assistant Director of Nursing	2,080	2,080	44,009	21.16	2
3	Registered Nurses	2,876	2,917	69,236	23.74	3
4	Licensed Practical Nurses	20,230	20,905	414,245	19.82	4
5	CNAs & Orderlies	61,238	63,114	606,406	9.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,008	2,048	21,092	10.30	9
10	Activity Assistants	504	504	4,788	9.50	10
11	Social Service Workers	1843	1,916	29,473	15.38	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,148	12.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,979	14,576	127,371	8.74	15
16	Dishwashers					16
17	Maintenance Workers	4,160	4,160	47,265	11.36	17
18	Housekeepers	19,879	20,668	191,108	9.25	18
19	Laundry	2,606	2,726	22,697	8.33	19
20	Administrator	2,080	2,080	58,333	28.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,943	2,007	18,473	9.20	23
24	Clerical					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>See Sch. PG20A</u>	5,932	6,020	111,848	18.58	33
34	TOTAL (lines 1 - 33)	145,011	149,374	\$ 1,832,383 *	\$ 12.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,000	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,000		49

C. CONTRACT NURSES

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

Sunset Manor Nursing Home
0046094
Period Beginning 1/1/2009
Period End 12/31/2009

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,960	1,992	45,196	22.69
Marketing	693	693	12,000	17.32
Transportation	1,199	1,255	11,389	9.07
Restorative Nurse	2,080	2,080	43,263	20.80
TOTAL (lines 1 - 35)	5,932	6,020	111,848	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Margaret Ferris	Administrator	0	\$ 58,333	Workers' Compensation Insurance	\$ 178,996	IDPH License Fee	\$	
				Unemployment Compensation Insurance	27,381	Advertising: Employee Recruitment	198	
				FICA Taxes	135,120	Health Care Worker Background Check		
				Employee Health Insurance	149,833	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	169	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	225	
				Employee Relations	1,847	Miscellaneous Dues & Subscriptions	977	
				Employee Retirement	843	IHCA Dues	1,500	
				Employee Life Insurance	137	Home Office Allocation	2,137	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 58,333					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense (977)	
			\$				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 2,925			\$	Out-of-State Travel	\$
AT & T	Computer Services		480					
LTC Solutions	Computer Services		1,700					
Muzak LLC	Computer Services		54	N/A			In-State Travel	
SimpleLTC, Inc.	Computer Services		81					
							Seminar Expense	
							Home Office Allocation	176
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,240				TOTAL	
							\$ 176	

* Attach copy of IMRF notifications

**See instructions.

Sunset Rehabilitation & Hlth C

0046094

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,240

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	49
GoffWilson, P.A.	Legal	70
Jackson Lewis	Legal	550
Peter Gartelos	Legal	53
Misc.	Legal	47
Ginoli & Company	Accountants	1,220
Miscellaneous Vendors	Computer Services	51
Emdeon Business Services	Computer Services	23
Advanced Answers on Demand	Computer Services	2,947
Access 2 Go	Computer Services	283
Ivans	Computer Services	33
Kemper Technology	Computer Services	801
VisionShare	Computer Services	249
MediFax	Computer Services	102
LogmeIn	Computer Services	44
Charter Communications	Computer Services	2
Simple LTC	Computer Services	680
Miscellaneous Vendors	Miscellaneous	466
Total (agree to Schedule V, line 19, column 8)		<u>12,910</u>

Facility Name & ID Number Sunset Rehabilitation & Hlth C# 0046094Report Period Beginning: 1/1/2009Ending: 12/31/2009**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. 1,500 IHCA
- (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? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 62,963
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ _____
- (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. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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.