FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0046094

Facility Name: Sunset Rehabilitation & Health Care

Address: 129 South 1st Avenue (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: (309) 674-4327 **Fax #** (309) 674-4354

HFS ID Number:

Date of Initial License for Current Owners: 08/01/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,919	1,919	8
9	SNF/PED					9
10	ICF	25,505	5,107		30,612	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,505	5,107	1,919	32,531	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.50%

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 [X] 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 [X]

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 [X] Date 08/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 1,505

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	159,299	19,820		179,119		179,119	6,059	185,178			1
2	Food Purchase		206,296		206,296		206,296	(42,936)	163,360			2
3	Housekeeping	218,034	26,942		244,976		244,976	72	245,048			3
4	Laundry	14,643	15,018		29,661		29,661		29,661			4
5	Heat and Other Utilities			124,118	124,118		124,118	602	124,720			5
6	Maintenance	48,647	16,707	20,145	85,499		85,499	3,527	89,026			6
7	Other (specify):* Home Off. Ben. All.							1,420	1,420			7
8	**TOTAL General Services**	440,623	284,783	144,263	869,669		869,669	(31,256)	838,413			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,286,411	71,486	3,516	1,361,413		1,361,413	(420)	1,360,993			10
10a	Therapy			229,554	229,554		229,554		229,554			10a
11	Activities	37,530	370	1,642	39,542		39,542		39,542			11
12	Social Services	37,168			37,168		37,168		37,168			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	1,361,109	71,856	252,712	1,685,677		1,685,677	(420)	1,685,257			16
	C. General Administration											
17	Administrative			78,000	78,000		78,000	(9,010)	68,990			17
18	Directors Fees											18
19	Professional Services			7,221	7,221		7,221	6,714	13,935			19
20	Dues, Fees, Subscriptions & Promotions			11,259	11,259		11,259	1,663	12,922			20
21	Clerical & General Office Expenses	16,456	8,315	10,682	35,453		35,453	60,309	95,762			21
22	Employee Benefits & Payroll Taxes			430,537	430,537		430,537		430,537			22
23	Inservice Training & Education							433	433			23
24	Travel and Seminar							50	50			24
25	Other Admin. Staff Transportation			8,678	8,678		8,678	5,427	14,105			25
26	Insurance-Prop.Liab.Malpractice			45,236	45,236		45,236	900	46,136			26
27	Other (specify):* Home Off. Ben. All.							24,611	24,611			27
28	**TOTAL General Administration**	16,456	8,315	591,613	616,384		616,384	91,097	707,481			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,818,188	364,954	988,588	3,171,730		3,171,730	59,421	3,231,151			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 Rehabilitation & Health Care #0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			104,058	104,058		104,058	46,476	150,534			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			211,961	211,961		211,961	3,752	215,713			32
33	Real Estate Taxes			38,032	38,032		38,032	(453)	37,579			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,460	18,460		18,460	832	19,292			35
36	Other (specify):*											36
37	TOTAL Ownership			372,511	372,511		372,511	50,607	423,118			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,391		64,391		64,391		64,391			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		903	1,811	2,714		2,714	(2,714)				43
44	TOTAL Special Cost Centers		65,294	64,774	130,068		130,068	(2,714)	127,354			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,818,188	430,248	1,425,873	3,674,309		3,674,309	107,314	3,781,623			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 Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,546)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,584)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,496	30		9
10	Interest and Other Investment Income	(4,292)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(234)	43		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	340	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	14,827	43		24
25	Fund Raising, Advertising and Promotional	(6,125)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(46,154)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,272)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	119,586	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 119,586		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 107,314		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Sunset Rehabilitation & Health Care

ID# 0046094

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,087)	43	1
2	X-Rays-Part A	(1,093)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(512)	10	3
4	Resident Flowers	(720)	43	4
5	Disallowed Real Estate Tax Late Fees	(1,314)	33	5
6	Offset Meals on Wheels Revenue	(39,390)	2	6
7	Disallowed Special Events	(38)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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**	(46,154)		49

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 B. 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. [X] 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	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 6,059	$ 6,059	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	72	72	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	602	602	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,527	3,527	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,420	1,420	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	92	92	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%	0		10
11	V	17	Administrative	78,000	Petersen Health Care, Inc.	100.00%	68,990	(9,010)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,714	6,714	12
13	V								13
14	Total			$ 78,000			$ 87,476	$ * 9,476	14

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

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs and Promotions	$	Petersen Health Care, Inc.	100.00%	$ 1,663	$ 1,663	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	60,309	60,309	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	433	433	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	50	50	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	5,427	5,427	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	900	900	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	24,611	24,611	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,980	6,980	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	8,044	8,044	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	861	861	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	832	832	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 110,110	$ * 110,110	39

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

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	178,117	1.24	2.07	Salary	$ 4,133	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 4,133		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 Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,527,029	77	$ 284,427	$ 283,010	32,531	$ 6,059	1
2	2	Food	Resident Days	1,527,029	77	0	0	32,531	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	32,531	72	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	32,531	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	32,531	602	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	32,531	3,527	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	32,531	1,420	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	32,531	92	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	32,531	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	32,531	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	32,531	68,990	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	32,531	6,714	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	32,531	1,663	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	32,531	60,309	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	32,531	433	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	32,531	50	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	32,531	5,427	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	32,531	900	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	32,531	24,611	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	32,531	6,980	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	32,531	8,044	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	32,531	861	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	32,531	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	32,531	832	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 197,586	25

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	Varies	08/31/02	$ 4,050,000	$ 3,826,331	12/31/13	Varies	$ 211,961	1
2												2
3							Interest Income Offset				(4,292)	3
4							Home Office Allocation-PHC				8,044	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,050,000	$ 3,826,331			$ 215,713	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,050,000	$ 3,826,331			$ 215,713	15

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

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

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

Facility Name & ID Number Sunset Rehabilitation & Health Care **#** 0046094 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 33,900	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.)	**2009**	$ 34,773	2
3. Under or (over) accrual (line 2 minus line 1).		$ 873	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 35,845	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.	**Home Office Allocation**	861	
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.		$ 37,579	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	33,983	8
2006	34,224	9
2007	32,153	10
2008	32,901	11
2009	34,773	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunset Rehabilitation & Health Care COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0046094

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-100-14-00	Long-Term Care Facility	$ 34,773.38	$ 34,773.38
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,773.38	$ 34,773.38

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	41,382	2002	$ 95,000	1
2					2
3	TOTALS	41,382		$ 95,000	3

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	105		2002	1972	$ 2,315,000	$	30	$ 77,167	$ 77,167	$ 655,919	4
5				2001	413,768		20	20,688	20,688	196,536	5
6	2			2003	148,271		20	7,414	7,414	55,605	6
7	8			2005	355,587		39	9,118	9,118	50,149	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			1,780	12
13	Petersen Properties Building Partnership			1995	13,199		20	660	660	10,386	13
14											14
15	Field Audit			1990	1,102		15			1,102	15
16	Drapes			1995	8,206		20	410	410	6,287	16
17	Remodeling			1996	14,630		20	732	732	10,372	17
18	Awning			1996	1,105		20	55	55	775	18
19	Landscaping			1996	4,036		20	202	202	2,963	19
20	Back Taxes on Land			1996	531		20	27	27	344	20
21	Tiling			1997	500		20	25	25	325	21
22	Doors			1997	5,250		20	263	263	3,682	22
23	Tiling			1997	8,228		20	411	411	5,720	23
24	Gutters			1997	2,759		20	138	138	1,898	24
25	Landscaping			1997	1,886		20	94	94	1,293	25
26	Door Closer			1997	1,688		20	84	84	1,120	26
27	Concrete Slab			1997	1,440		20	72	72	984	27
28	Painting			1997	1,207		20	60	60	825	28
29	Furnace			1997	2,389		20	119	119	1,567	29
30	Awning			1997	4,077		20	204	204	2,754	30
31	Telephone System			1997	1,189		20	59	59	782	31
32	Roof/Windows			1998	36,145		20	1,807	1,807	22,588	32
33	Drapery			1998	1,402		20	70	70	875	33
34	Expansion Design			1998	3,639		20	182	182	2,275	34
35	Flooring/Cove Base			1998	619		20	31	31	388	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 & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	
37	Awnings	1999	$ 353	$	20	$ 18	$ 18	$ 207	37
38	Roof (Balance)	1999	1,000		20	50	50	575	38
39	Drapes	2000	1,966		20	98	98	1,029	39
40	Remove Trees	2000	1,072		20	54	54	567	40
41	Expansion	2000	1,945		20	97	97	1,023	41
42	Wood	2000	1,072		20	54	54	567	42
43	Land Work	2000	2,510		20	126	126	1,323	43
44	Flooring	2000	1,168		20	58	58	609	44
45	Shades	2001	1,788		20	89	89	846	45
46	Painting	2001	2,228		20	111	111	1,055	46
47	Carpet	2001	4,841		20	242	242	2,299	47
48	Carpet	2001	8,000		20	400	400	3,800	48
49	Painting	2001	345		20	17	17	162	49
50	Fire System	2001	42,286		20	2,114	2,114	20,083	50
51	Carpet	2001	2,155		20	108	108	1,026	51
52	Kitchen Remodeling	2001	43,315		20	2,166	2,166	20,577	52
53	Expansion	2002	7,352		20	368	368	3,130	53
54	Wall	2002	6,000		20	300	300	2,550	54
55	New Addition	2004	3,021		20	151	151	983	55
56	Stairway, sunroom, new addition	2004	218,275		20	10,914	10,914	70,941	56
57	Engineering Fees	2005	2,047		20	102	102	561	57
58	IDPH Planning Fee	2005	2,976		20	149	149	819	58
59	Architect Fees	2005	1,904		20	98	98	535	59
60	Asphalt West Lot	2006	21,480		20	1,074	1,074	5,012	60
61	Air Conditioner	2007	3,000		10	300	300	1,050	61
62	Wheelchair Ramp	2007	930		15	62	62	217	62
63	Fencing	2008	3,634		39	94	94	235	63
64	Generator Repair	2009	3,214		7	460	460	690	64
65	Boiler and Mixing Valve Repair	2009	5,449		7	778	778	1,167	65
66	Boiler Repair	2009	2,582		7	368	368	552	66
67	Air Conditioner-Dining Room	2009	3,834		7	548	548	822	67
68	Roof Installation	2009	6,752		15	450	450	675	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,779,390	$		$ 142,110	$ 142,110	$ 1,206,244	70

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

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$		$ 142,110	$ 142,110	$ 1,206,244	1
2	Sunroom	2009	10,779		35	308	308	462	2
3	Water Heater	2010	6,518		7	466	466	466	3
4	Air Conditoner Repair	2010	3,308		7	236	236	236	4
5	Boiler	2010	14,000		20	350	350	350	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	Land Improvements Booked			419			(419)		21
22	Building Booked			59,359			(59,359)		22
23	Building Improvements Booked			38,588			(38,588)		23
24									24
25									25
26	2010-Home Office Allocation-Building Improvements		15,636			375	375		26
27	2010-Home Office Allocation-Land Improvements		1,460			81	81		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,831,091	$ 98,366		$ 143,926	$ 45,560	$ 1,207,758	34

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

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$ 14,126	$ 5,092	$ 1,575	$ (3,517)	7-10 yrs.	$ 5,524	71
72	Current Year Purchases	8,904	600	445	(155)	10 yrs.	445	72
73	Fully Depreciated Assets	530,696					530,696	73
74	Home Office Allocation			4,588	4,588			74
75	TOTALS	$ 553,726	$ 5,692	$ 6,608	$ 916		$ 536,665	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	$	$	$		$ 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	$	$	$		$ 139,290	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)	$ 4,619,107	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,058	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 150,534	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 46,476	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,883,713	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	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 12,354 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

* 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 & Health Care
0046094
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$	6,111
Copier		5,411
Home Office Allocation		832
		12,354

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	6,225	$ 93,386	$	6,225	$ 93,386	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		764	11,461		764	11,461	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,313	124,707		8,313	124,707	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				64,391		64,391	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			$	15,302	$ 229,554	$ 64,391	15,302	$ 293,945	14

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

STATE OF ILLINOIS

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 3,687,322	$ 3,687,322	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 34,000)	280,526	280,526	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,008	31,008	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)**	$ 4,013,877	$ 4,013,877	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	3,248,262	14
15	Leasehold Improvements, at Historical Cost	1,020,949	582,829	15
16	Equipment, at Historical Cost	709,135	693,016	16
17	Accumulated Depreciation (book methods)	(1,481,230)	(1,883,713)	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): Goodwill	1,790,000	1,790,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,912,643	$ 4,525,394	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,926,520	$ 8,539,271	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 687,580	$ 687,580	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,499	114,499	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,998	18,998	31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,845	35,845	32
33	Accrued Interest Payable	18,641	18,641	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	46,466	46,466	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 922,029	$ 922,029	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,826,331	3,826,331	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans Due To	78,000	78,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,904,331	$ 3,904,331	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,826,360	$ 4,826,360	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,100,160	$ 3,712,911	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,926,520	$ 8,539,271	48

*(See instructions.)

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,862,871	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,862,871	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	237,289	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)**	$ 237,289	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)**	$ 4,100,160	24 *

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

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,586,867	1
2	Discounts and Allowances for all Levels	(193,056)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,393,811	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	341,891	6
7	Oxygen	921	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 342,812	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	3,546	14
15	Telephone, Television and Radio	300	15
16	Rental of Facility Space		16
17	Sale of Drugs	118,630	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,418	20
21	Other Medical Services	2,887	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 130,781	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,292	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,292	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	512	28
28a	Meals on Wheels Revenue	39,390	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,902	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,911,598	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	869,669	31
32	Health Care	1,685,677	32
33	General Administration	616,384	33
	B. Capital Expense		
34	Ownership	372,511	34
	C. Ancillary Expense		
35	Special Cost Centers	67,105	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)***	$ 3,674,309	40
41	**Income before Income Taxes (line 30 minus line 40)****	237,289	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 237,289	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 & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,287	2,382	$ 66,016	$ 27.71	1
2	Assistant Director of Nursing	2,714	2,744	44,669	16.28	2
3	Registered Nurses	2,080	2,080	50,750	24.40	3
4	Licensed Practical Nurses	21,360	22,168	444,189	20.04	4
5	CNAs & Orderlies	58,036	60,142	588,090	9.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,989	2,053	21,786	10.61	9
10	Activity Assistants	30	30	309	10.30	10
11	Social Service Workers	2,518	2,518	37,168	14.76	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,902	12.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,254	13,954	133,397	9.56	15
16	Dishwashers					16
17	Maintenance Workers	4,160	4,160	48,647	11.69	17
18	Housekeepers	23,033	24,297	218,034	8.97	18
19	Laundry	1,693	1,765	14,643	8.30	19
20	Administrator	2,105	2,105	64,857	30.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,803	1,815	16,456	9.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	5,754	5,834	108,132	18.53	33
34	TOTAL (lines 1 - 33)	144,896	150,127	$ 1,883,045 *	$ 12.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,083	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7	325	10(3)	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)	7	$ 23,408		49

C. CONTRACT NURSES

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

Sunset Rehabilitation & Health Care

Period Beginning **1/1/2010**
Period End **12/31/2010**

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	2,194	2,258	51,990	23.02
Restorative Nurse	1,915	1,915	40,707	21.26
Transportation	1,645	1,661	15,435	9.29
TOTAL	5,754	5,834	108,132	

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret Ferris	Administrator	0	$ 11,000
Misty Little	Administrator	0	20,801
William Oster	Administrator	0	33,056
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,857

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 78,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 78,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,645
AT & T	Computer Services	480
Fulton County Circuit Clerk	Legal Services	96
Clifton Gunderson LLP	Accounting Services	3,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 7,221

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 159,435
Unemployment Compensation Insurance	35,529
FICA Taxes	137,054
Employee Health Insurance	93,945
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,625
Employee Retirement	1,871
Life Insurance	78
TOTAL (agree to Schedule V, line 22, col.8)	$ 430,537

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	2,131
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks 173	1,732
Miscellaneous Licenses & Permits	851
Miscellaneous Dues & Subscriptions	0
IHCA Dues	0
Home Office Allocation	1,663
Curaspan Health Group	2,565
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,922

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	50
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 50

* Attach copy of IMRF notifications

**See instructions.

Sunset Rehabilitation & Health Care
0046094
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		7,221
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	6
Healthcare Resources International	Legal	83
Ginoli & Company	Accountants	1,187
Bank of America	Accountants	261
Miscellaneous Vendors	Computer Services	38
VisionShare	Computer Services	357
Advanced Answers on Demand	Computer Services	2,245
Access 2 Go	Computer Services	365
Kemper Technology	Computer Services	309
MediFax	Computer Services	128
Logmeln	Computer Services	91
Simple LTC	Computer Services	1,431
Optimizer Systems	Other Professional Fees	52
Clifton Gunderson	Other Professional Fees	161
Total (agree to Schedule V, line 19, column 8)		13,935

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **0 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? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,330** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **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? **N/A** 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. $ **3,546**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **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? 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.