		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0011643

Facility Name: SUNSET HOME

Address: 418 WASHINGTON (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-223-2636 **Fax #** 217-223-9867

HFS ID Number:

Date of Initial License for Current Owners: NOT AVAILABLE

Type of Ownership:

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

IRS Exemption Code 501C(3)

In the event there are further questions about this report, please contact:
Name: KELLEY HATFIELD **Telephone Number:** 217-223-2636 EXT 311
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 10/01/2010 to 09/30/2011 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) CHRIS HOPSON
(Title) CEO/ADMINISTRATOR

Paid Preparer
(Signed) (Date)
(Print Name and Title) TIMOTHY J WIEWEL, OWNER
(Firm Name & Address) TIMOTHY J WIEWEL CPA, PO BOX 1028 QUINCY IL 62306
(Telephone) 217-223-2245 Fax # 217-223-7580

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 HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

III. STATISTICAL DATA

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

	1 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	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	118	Intermediate (ICF)	118	43,070	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	182	TOTALS	182	66,430	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			5,529	5,529	8
9	SNF/PED					9
10	ICF	24,139			24,139	10
11	ICF/DD			25,046	25,046	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,139		30,575	54,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.36%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
INDIVIDUAL LIVING UNITS, SENIOR APARTMENTS

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 5,529

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

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

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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	507,031	29,411	15,681	552,123		552,123		552,123			1
2	Food Purchase		338,714		338,714		338,714		338,714			2
3	Housekeeping	254,451	65,135		319,586		319,586		319,586			3
4	Laundry	43,918	606	146,546	191,070		191,070		191,070			4
5	Heat and Other Utilities			366,244	366,244		366,244	(22,616)	343,628			5
6	Maintenance	116,588	71,822	101,738	290,148		290,148		290,148			6
7	Other (specify):*											7
8	TOTAL General Services	921,988	505,688	630,209	2,057,885		2,057,885	(22,616)	2,035,269			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,451,432	159,500	101,628	3,712,560		3,712,560		3,712,560			10
10a	Therapy			479,793	479,793		479,793		479,793			10a
11	Activities	115,724	14,212	2,572	132,508		132,508		132,508			11
12	Social Services	106,522	548	18,862	125,932		125,932		125,932			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,673,678	174,260	602,855	4,450,793		4,450,793		4,450,793			16
	C. General Administration											
17	Administrative	148,856			148,856		148,856		148,856			17
18	Directors Fees											18
19	Professional Services			62,151	62,151		62,151	(12,343)	49,808			19
20	Dues, Fees, Subscriptions & Promotions			14,851	14,851		14,851		14,851			20
21	Clerical & General Office Expenses	279,086	24,196	170,654	473,936		473,936	(63,065)	410,871			21
22	Employee Benefits & Payroll Taxes			1,198,857	1,198,857		1,198,857		1,198,857			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,820	17,820		17,820	(7,978)	9,842			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			134,899	134,899		134,899		134,899			26
27	Other (specify):* BAD DEBT			14,747	14,747		14,747	(14,747)				27
28	TOTAL General Administration	427,942	24,196	1,613,979	2,066,117		2,066,117	(98,133)	1,967,984			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,023,608	704,144	2,847,043	8,574,795		8,574,795	(120,749)	8,454,046			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SUNSET HOME #0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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			555,921	555,921	(131,920)	424,001		424,001			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,561	87,561		87,561		87,561			32
33	Real Estate Taxes			896	896		896		896			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			644,378	644,378	(131,920)	512,458		512,458			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,123		113,123		113,123		113,123			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,630	102,630		102,630		102,630			42
43	Other (specify):*			488,991	488,991	131,920	620,911	(649,617)	(28,706)			43
44	**TOTAL Special Cost Centers**		113,123	591,621	704,744	131,920	836,664	(649,617)	187,047			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,023,608	817,267	4,083,042	9,923,917		9,923,917	(770,366)	9,153,551			45

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(22,616)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,343)	19		22
23	Malpractice Insurance for Individuals	(28,706)	43		23
24	Bad Debt	(14,747)	27		24
25	Fund Raising, Advertising and Promotional	(28,706)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (107,118)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,118)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SUNSET HOME

ID# 0011643

Report Period Beginning: 10/01/2010

Ending: 09/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OUT OF STATE TRAVEL	$ (7,978)	24	1
2	VILLA INDEP UNITS	(92,626)	43	2
3	SENIOR APARTMENTS	(499,579)	43	3
4	MARKETING WAGES EVENTS AND SUPPLIES	(63,065)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(663,248)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/01/2010 **Ending:** 09/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(22,616)	0	0	0	0	0	0	0	0	0	0	(22,616)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(22,616)	0	0	0	0	0	0	0	0	0	0	(22,616)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,343)	0	0	0	0	0	0	0	0	0	0	(12,343)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(63,065)	0	0	0	0	0	0	0	0	0	0	(63,065)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,978)	0	0	0	0	0	0	0	0	0	0	(7,978)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(14,747)	0	0	0	0	0	0	0	0	0	0	(14,747)	27
28	**TOTAL General Administration**	(98,133)	0	0	0	0	0	0	0	0	0	0	(98,133)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(120,749)	0	0	0	0	0	0	0	0	0	0	(120,749)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/01/2010 **Ending:** 09/30/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(649,617)	0	0	0	0	0	0	0	0	0	0	(649,617)	43
44	**TOTAL Special Cost Centers**	(649,617)	0	0	0	0	0	0	0	0	0	0	(649,617)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(770,366)	0	0	0	0	0	0	0	0	0	0	(770,366)	45

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

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

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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

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

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 9/30/2011

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 ☐

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

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

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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	MERCANTILE		X	RENOVATION 1,2,4	$16,900.00	12/19/03	$ 2,150,000	$ 1,763,079	12/19/28	0.0475	$ 87,560	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$16,900.00		$ 2,150,000	$ 1,763,079			$ 87,560	9
	B. Non-Facility Related*											
10	MERCANTILE		X	APARTMENT PERM LOAN	$13,286.00	12/19/03	2,850,000	2,383,752	12/19/28	0.0475	116,523	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$13,286.00		$ 2,850,000	$ 2,383,752			$ 116,523	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 4,146,831			$ 204,083	15

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

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

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 896	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.)		$ 896	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 896	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	1,040	8
2007	796	9
2008	831	10
2009	863	11
2010	896	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT KELLYEY HATTFIELD

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-2-0917-000-00	VACANT LOT	$ 105.52	$
2.	23-2-0926-000-00	VACANT LOT	$ 208.26	$
3.	23-2-0971-000-00	VACANT LOT	$ 150.94	$
4.	23-2-0972-000-00	VACANT LOT	$ 49.62	$
5.	23-2-0973-000-000	VACANT LOT	$ 49.62	$
6.	23-2-0974-000-00	VACANT LOT	$ 85.26	$
7.	23-2-0975-000-00	VACANT LOT	$ 148.16	$
8.	23-2-0979-000-00	VACANT LOT	$ 98.64	$
9.			$	$
10.			$	$
		TOTALS	$ 896.02	$

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

VILLA PARTMENTS 16 2 BEDROOM UNITS 16,000 SG FT

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	199,487		$ 102,419	1
2	PARKING LOT ADDITIONAL	15,000	1996-97	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	34		1958	1958	$ 354,000	$	50	$	$	$ 354,000	4
5	51		1971	1971	1,218,562	24,371	50	24,371		974,822	5
6	49		1972	1972	472,577	9,452	50	9,452		375,705	6
7	5		1987	1987	68,497		50			68,497	7
8	43		2001	2001	2,500,281	83,343	50	83,343		833,427	8
	Improvement Type**										
9	BUILDING IMPROVENTS			1958	12,000		10			12,000	9
10	BUILDING IMPROVENTS			1972	51,124	1,023	50	1,023		39,883	10
11	BUILDING IMPROVENTS			1977	14,179		20			14,179	11
12	BUILDING IMPROVENTS			1978	442,103	8,842	50	8,842		296,323	12
13	BUILDING IMPROVENTS			1979	13,639	273	50	273		8,869	13
14	BUILDING IMPROVENTS			1980	771		20			771	14
15	BUILDING IMPROVENTS			1981	3,742		10			3,742	15
16	BUILDING IMPROVENTS			1982	13,900		10			13,900	16
17	BUILDING IMPROVENTS			1983	14,951		20			14,951	17
18	BUILDING IMPROVENTS			1985	272,013	6,800	40	6,800		178,952	18
19	BUILDING IMPROVENTS			1987	321,886		10-20			321,885	19
20	BUILDING IMPROVENTS			1988	36,315		10-20			36,315	20
21	BUILDING IMPROVENTS			1989	99,114		20			99,114	21
22	BUILDING IMPROVENTS			1990	36,949	1,775	20	1,775		36,949	22
23	BUILDING IMPROVENTS			1992	11,222	156	10-20	156		11,111	23
24	BUILDING IMPROVENTS			1993	31,474	1,151	10-20	1,151		29,307	24
25	BUILDING IMPROVENTS			1994	9,466	382	5-20	382		8,512	25
26	BUILDING IMPROVENTS			1995	99,649		5-15			99,649	26
27	BUILDING IMPROVENTS			1996	25,111	1,256	20	1,256		19,016	27
28	BUILDING IMPROVENTS			1997	356,451	16,724	5-20	16,724		264,468	28
29	BUILDING IMPROVENTS			1998	107,004	5,087	5-20	5,087		73,940	29
30	BUILDING IMPROVENTS			1999	1,696		10			1,696	30
31	BUILDING IMPROVENTS			2000	30,811	1,540	20	1,540		16,585	31
32	BUILDING IMPROVENTS			2001	24,121	1,814	10-20	1,814		21,788	32
33	BUILDING IMPROVENTS			2002	48,990	4,460	10-20	4,460		41,936	33
34	BUILDING IMPROVENTS			2004	16,042	1,018	5-20	1,018		8,890	34
35	BUILDING IMPROVENTS			2006	56,337	2,817	20	2,817		15,493	35
36	BUILDING IMPROVENTS			2007	2,802,081	115,217	15-25	115,217		518,478	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	124 RENOVATION LEANDER CONST	2008	$ 52,103	$ 2,084	25	$ 2,084	$	$ 7,294	37
38	124 RENOVATION LZT ARCHITECHT	2008	4,117	164	25	164		574	38
39	124 RENOVATION ATTORNEY FEES CAPITALIZED	2008	1,588	64	25	64		224	39
40	COPPER ROOF	2009	10,798	1,080	10	1,080		2,700	40
41	HAND RAILS	2009	11,359	757	15	757		1,893	41
42	HAND RAILS WALL GUARD	2010	12,954	864	15	864		1,296	42
43	HAND RAILS WALL GUARD	2011	14,560	485	15	485		485	43
44									44
45	FIXED EQUIPMENT	1971	814,827		25			814,827	45
46	FIXED EQUIPMENT	1972	253,064		25			253,063	46
47	FIXED EQUIPMENT	1978	280,726		25			280,726	47
48	FIXED EQUIPMENT	1979	13,938		10			13,938	48
49	FIXED EQUIPMENT	1984	23,531		10			23,531	49
50	FIXED EQUIPMENT	1985	117,689		5-20			117,687	50
51									51
52	FIXED EQUIPMENT	1986	13,909		10-15			13,908	52
53	FIXED EQUIPMENT	1987	12,320		10-20			12,320	53
54	FIXED EQUIPMENT	1988	8,162		10-20			8,162	54
55	FIXED EQUIPMENT	1989	4,670		15			4,670	55
56	FIXED EQUIPMENT	1993	259,307	11,891	10-20	11,891		239,490	56
57	FIXED EQUIPMENT	1995	188,017	9,129	10-20	9,129		155,409	57
58	FIXED EQUIPMENT	1996	10,809	44	10-15	44		10,809	58
59	FIXED EQUIPMENT	1997	35,461	1,812	15-20	1,812		25,963	59
60	FIXED EQUIPMENT	1998	173,001	8,865	15-20	8,865		119,595	60
61	FIXED EQUIPMENT	1999	8,744	526	15-20	526		6,222	61
62	FIXED EQUIPMENT	2000	272,461	14,155	10-20	14,155		158,645	62
63	FIXED EQUIPMENT	2001	40,619	2,424	10-20	2,424		23,969	63
64	FIXED EQUIPMENT	2002	81,604	5,504	10-20	5,504		49,923	64
65	FIXED EQUIPMENT	2003	105,075	6,172	10-20	6,172		50,383	65
66	FIXED EQUIPMENT	2004	142,116	8,970	15-20	8,970		62,387	66
67	FIXED EQUIPMENT	2005	51,320	3,262	10-25	3,262		25,892	67
68	FIXED EQUIPMENT	2007	14,507	838	15-25	838		3,774	68
69	CHILLER REPLACEMENT	2008	24,923	1,662	15	1,662		5,816	69
70	TOTAL (lines 4 thru 69)		$ 12,625,337	$ 368,253		$ 368,253	$	$ 7,310,728	70

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 12,625,337	$ 368,253		$ 368,253	$	$ 7,310,728	1
2	30 CONCENTRATORS	2009	12,443	830	15	830		2,074	2
3	SMOKE DEETECTORS	2009	2,803	187	15	187		467	3
4	GENERATOR TRANSFER SWITCH	2009	3,000	150	20	150		375	4
5	HATCO BOOSTER HEATER DIETARY	2010	2,581	258	10	258		387	5
6	BOILER FOR WATER HEATER	2011	6,954	464	15	464		464	6
7	SECURITY CAMERA	2011	11,216	748	15	748		748	7
8									8
9	LAND IMPROVEMENTS	1975	2,807		25			2,807	9
10	LAND IMPROVEMENTS	1978	495		10			495	10
11	LAND IMPROVEMENTS	1979	6,425		10			6,425	11
12	LAND IMPROVEMENTS	1992	56,865		10			56,865	12
13	LAND IMPROVEMENTS	1995	18,601		12			18,601	13
14	LAND IMPROVEMENTS	1997	4,800	192	25	192		2,784	14
15	LAND IMPROVEMENTS	1999	44,219	3,685	12	3,685		46,063	15
16	LAND IMPROVEMENTS	2000	17,559	707	10-25	707		14,876	16
17	LAND IMPROVEMENTS	2001	1,952	99	10	99		1,952	17
18	LAND IMPROVEMENTS	2003	8,404	560	15	560		4,761	18
19	LAND IMPROVEMENTS	2004	3,450	230	15	230		1,725	19
20	LAND IMPROVEMENTS	2006	20,477	2,048	10	2,048		11,263	20
21	LANDSCAPING	2011	11,881	594	10	594		594	21
22									22
23									23
24									24
25	ROUNDING		(4)	(8)		(8)			25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,862,265	$ 378,997		$ 378,997	$	$ 7,484,454	34

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 520,073	$ 37,209	$ 37,209	$		$ 334,372	71
72	Current Year Purchases	98,348	6,675	6,675			6,675	72
73	Fully Depreciated Assets	422,893					422,893	73
74								74
75	TOTALS	$ 1,041,314	$ 43,884	$ 43,884	$		$ 763,940	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINTENANCE	97 3/4 TON GMC & PLOW	1997	$ 23,521	$	$	$		$ 23,521	76
77	RESIDENT TRANSPORT	2001 E-450 FORD BUS	2001	56,836					56,836	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216					36,216	78
79	RESIDENT TRANSPORT	2005 TRANSPORT BUS	2005	50,391					50,391	79
80	TOTALS			$ 166,964	$	$	$		$ 166,964	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,259,250	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 422,881	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 422,881	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,415,358	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VILLA INDEP UNITS	$ 1,762,254	$ 48,377	$ 1,003,005	86
87	SUNSET APARTMENTS	2,855,144	83,583	650,590	87
88					88
89					89
90					90
91	TOTALS	$ 4,617,398	$ 131,960	$ 1,653,595	91

G. Construction-in-Progress

	Description	Cost	
92	SPRINKLER SYSTEM	$ 46,600	92
93			93
94			94
95		$ 46,600	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 HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   COMMUNITY COLLEGE TRAINS AIDES

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.

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	$		$ 170,307	$		$ 170,307	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			58,223			58,223	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			242,265			242,265	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				113,123		113,123	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			$		$ 470,795	$ 113,123		$ 583,918	14

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2011 (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	$ 1,287,406	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,581,267		3
4	Supply Inventory (priced at COST)	32,629		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,292		6
7	Other Prepaid Expenses	13,238		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,967,832	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,707		13
14	Buildings, at Historical Cost	12,862,265		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,208,278		16
17	Accumulated Depreciation (book methods)	(8,415,358)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,650,357		21
22	Other Long-Term Assets (specify):	5,213,718		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,707,967	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,675,799	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 103,717	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	301,429		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SUNSET APERTMENTS	166,469		36
37	HEALTH CLAIMS PAYABLE	39,863		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 611,478	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,763,079		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	N/P SUSNET APARTMENTS	2,383,752		43
44	REF FEES DEFERRED REVENUE	23,108		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,169,939	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,781,417	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,894,382	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,675,799	$	48

***(See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,816,812	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,816,812	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,077,570	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,077,570	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)**	$ 11,894,382	24 *

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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	$ 11,160,830	1
2	Discounts and Allowances for all Levels	(1,553,488)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,607,342	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	361,981	24
25	Interest and Other Investment Income***	37,742	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 399,723	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	LIST ATTACHED	829,497	28
28a	CHANGE IN VALUE SPLIT-INTEREST AGREEMENT	164,925	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 994,422	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,001,487	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,057,885	31
32	Health Care	4,450,793	32
33	General Administration	2,066,117	33
	B. Capital Expense		
34	Ownership	644,378	34
	C. Ancillary Expense		
35	Special Cost Centers	113,123	35
36	Provider Participation Fee	102,630	36
	D. Other Expenses (specify):		
37	FUND DEVELOPMENT	28,706	37
38	SUNSET APARTMENTS	415,996	38
39	VILLA	44,289	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,923,917	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,077,570	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,077,570	43

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

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

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

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

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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	2,033	2,159	$ 64,695	$ 29.97	1
2	Assistant Director of Nursing	1,982	2,096	53,224	25.39	2
3	Registered Nurses	25,604	26,610	547,162	20.56	3
4	Licensed Practical Nurses	59,049	64,211	1,105,054	17.21	4
5	CNAs & Orderlies	134,628	141,942	1,560,413	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,974	2,096	25,208	12.03	9
10	Activity Assistants	9,626	10,015	90,058	8.99	10
11	Social Service Workers	5,899	6,724	87,443	13.00	11
12	Dietician					12
13	Food Service Supervisor	3,839	4,318	68,090	15.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,647	41,122	392,627	9.55	15
16	Dishwashers	4,070	4,279	46,592	10.89	16
17	Maintenance Workers	7,342	7,971	106,410	13.35	17
18	Housekeepers	23,426	24,983	228,890	9.16	18
19	Laundry	3,904	4,191	44,358	10.58	19
20	Administrator	1,982	2,663	127,967	48.05	20
21	Assistant Administrator					21
22	Other Administrative	4,630	5,968	127,915	21.43	22
23	Office Manager					23
24	Clerical	13,466	14,114	167,289	11.85	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	1,866	2,096	40,286	19.22	31
32	Other Health Care(specify)	4,135	4,353	52,363	12.03	32
33	Other(specify)	5,697	6,270	87,564	13.97	33
34	TOTAL (lines 1 - 33)	353,799	378,181	$ 5,023,608 *	$ 13.28	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		$ 13,436	1-3	35
36	Medical Director		3,600	10-3	36
37	Medical Records Consultant		5,230	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,977	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		1,075	11-3	44
45	Social Service Consultant		3,303	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 36,621		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRIS HOPSON	CEO/ADMIN		$ 127,967
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,967

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
GRAY HUNTER STENN LLP	AUDIT	$ 29,325
TIMOTHY J WIEWEL CPA	ACCTG	14,500
SCHOLZ LOOS PALMER SIEBERS	LEGAL	5,983
SCHOLZ LOOS PALMER SIEBERS	LEGAL CONTRIBUTIONS	12,343
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 62,151

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 219,613
Unemployment Compensation Insurance	16,297
FICA Taxes	389,812
Employee Health Insurance	509,888
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION 401K	39,830
EMPLOYEE AWARDS PERKS GIFTS	37,110
PHYSICALS SHOTS	2,209
LIFE INS	
VACATION PERSONAL TIME	(15,902)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,198,857

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
LIFE SERVICE NETWOR	9,406
TRI STATE HEALTHCARE	945
IDPH	3,312
OTHER DUES FEES	1,188
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,851

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,842
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,842

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

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													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/2010 Ending: 09/30/2011

XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,530** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **102,630**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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. $ **300,000**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **GAY HUNTER STENN LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees

SUNSET HOME #0011643 10/01/10-9/30/11

XVIII STAFFING & SALARY COSTS

LINE 32 - OTHER	1 # OF HRS. ACTUALLY WORKED	2 # OF HRS. PAID AND ACCRUED	3 TOTAL SALARIES AND WAGES	4 AVERAGE HOURLY WAGE
NRS-SUPPLY COORDINATOR	0	0	0	
NRS- TRANSPORTER	2,169	2,251	22,684	10.08
SOC SERV- DIRECTOR	1,960	2,096	29,582	14.11
NRS- CLERICAL	6	6	97	16.17
	4,135	4,353	52,363	
LINE 33 - OTHER				
MARKETING DIRECTOR	1,875	2,096	41,859	19.97
HOUSEKEEPING DIRECTOR	1,982	2,096	26,382	12.59
SUPPLY COORDINATOR	1,840	2,078	19,323	9.30
	5,697	6,270	87,564	

SUNSET HOME #0011643

BALANCE SHEET- SCH XV

SEPTEMBER 30, 2011

	OPERATING
LINE 23-OTHER	
VILLA BUILDING & EQUIPMENT NET OF DEPRECIATION (1,003,005)	763,483
SUNSET APARTMENTS LAND, BUILDING & EQUIPMENT NET OF DEPRECIATION (650,590	2,654,554
UNAMORTIZED BOND COSTS	73,339
ASSETS INTERNALLY (BOARD) DESIGNATED	268,598
OTHER ASSETS	7,115
CONSTRUCTION IN PROGRESS	46,600
ADDITIONAL LAND COSTS	395,311
LAND HELD FOR EXPANSION	1,004,718
	5,213,718

SUNSET HOME #0011643 SEPTEMBER 30, 2011

An interest income offset is not applicable at 9/30/11 because of the following reasons.

1) There has been a loss from operations for twenty-three of the last twenty-five years. So no additional monies have been generated from operations for investment purposes.

2) The majority of investments are derived from contributions and endowments.

SUNSET HOME
#0011643
10/01/10-9/30/11

XVII INCOME STATEMENT LINE 28 OTHER REVENUE

VILLA INDEPENDENT LIVING	144,489
SUNSET APARTMENTS RENTAL FEES	654,666
MISCELLANEOUS INCOME	30,342
	829,497

SUNSET HOME #0011643
COST CENTER SCH V
10/01/10-9/30/11

	SALARY 1	SUPPLIES 2	OTHER 3	TOTAL 4	RECLASS 5	RECLASS TOTAL 6	ADJUST 7	ADJUSTED TOTAL 8
LINE 43-OTHER								
FUND DEVELOP.			28,706	28,706		28,706	(28,706)	0
SUNSET APARTMENTS			415,996	415,996	83,583	499,579	(499,579)	0
VILLA			44,289	44,289	48,337	92,626	(92,626)	0
	0	0	488,991	488,991	131,920	620,911	(620,911)	0

SCHEDULE V LINE 23 IN-SERVICE TRAINING & EDUCATION SUNSET HOME #0011643 10-1-10/ 9-30-11 PA COST REPORT

Start Date	End Date	Who Attended	Title	Where	Seminar Name/Sponsor	Cost

SCHEDULE V LINE 24 TRAVEL & SEMINAR SUNSET HOME #0011643 10-1-10/ 9-30-11 PA COST REPORT

Start Date	End Date	Who Attended	Title	Where	Seminar Name/Sponsor	Cost
########	########	Sarah Barry	Social Serivce	Carlyle, IL	SSD Basic Training Course	$90.00
########	########	Diane Masters	Social Serivce	Carlyle, IL	SSD Basic Training Course	$90.00
3/16/2011	3/16/2011	Ron McCafferty	Housekeeping	Columbia, MO	Hillyard Floor Cleaning Seminar (Mileage)	$84.94
4/11/2011	4/15/2011	Theresa Taylor	Haven Coordinator	Atlanta, GA	AANAC Spring Conference	
4/11/2011	4/15/2011	LeAnn Vandermaiden	MDS Coordinator	Atlanta, GA	AANAC Spring Conference	
4/11/2011	4/15/2011	Lisa McDonald	Restorative Nurse	Atlanta, GA	AANAC Spring Conference	$7,977.75
4/18/2011	4/18/2011	Theresa Taylor	Haven Coordinator	St Louis, MO		$128.33
4/26/2011	4/26/2011	Diana Masters	Social Serivce	Peoria, IL	"Teepa Live"/Alzheimer Association	$223.16
4/26/2011	4/26/2011	Sarah Barry	Social Serivce	Peoria, IL	"Teepa Live"/Alzheimer Association	$100.00
9/12/2011	9/15/2011	Christine Hopson	CEO/Admistrator	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Jody James	DON	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Tammy Wiemelt	ADON	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Kelley Hatfield	Accounting Director	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Pam Fesseler	A/R	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Kham Kurfman	A/P	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Laura Feltes	HR Assistant	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Jeni Yeager	Social Serivce	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	LeAnn Vandermaiden	MDS Coordinator	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Lisa McDonald	Restorative Nurse	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Theresa Taylor	Haven Coordinator	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Lori Sullivan	Dietary Director	Peoria, IL	IHCA Annual Convention	
9/12/2011	9/15/2011	Mike Davis	Dietary Director	Peoria, IL	IHCA Annual Convention	$8,889.69
9/12/2011	9/15/2011	Angie Owsley	Dietary	Peoria, IL	IHCA Annual Convention	
9/19/2011	9/19/2011	Theresa Taylor	Haven Coordinator	Peoria, IL	Alzheimer's Executive Board	$236.57
						$17,820.44
						($7,977.75)
					TOTAL	$9,842.69