

		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: 0005009

Facility Name: Sunny Acres Nursing Home of Menard County

Address: 19130 Sunny Acres Road Petersburg 62575
Number City Zip Code

County: Menard

Telephone Number: 217-632-2334 Fax # 217-632-7092

HFS ID Number:

Date of Initial License for Current Owners: 1966

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT

☐ Charitable Corp.

☐ Trust

IRS Exemption Code

☐ PROPRIETARY

☐ Individual

☐ Partnership

☐ Corporation

☐ "Sub-S" Corp.

☐ Limited Liability Co.

☐ Trust

☐ Other

☒ GOVERNMENTAL

☐ State

☒ County

☐ Other

In the event there are further questions about this report, please contact:
Name: Mrs. Patricia McNeal Telephone Number: 217-632-2334
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 12/01/2010 to 11/30/2011 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)

(Type or Print Name) Mrs. Patricia McNeal

(Title)

Paid Preparer

(Signed)

(Print Name and Title) Mr. Michael J. Feriozzi Certified Public Accountant

(Firm Name & Address) Michael J. Feriozzi C.P.A. 1316 South Glenwood Springfield, Illinois 62704

(Telephone) 217-522-8689 Fax # 217-632-7092

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 Sunny Acres Nursing Home of Menard County

0005009 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,033	13,395	3,271	35,699	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,033	13,395	3,271	35,699	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.27%

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)
meals for menard county inmates

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/01/1966

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 106 and days of care provided 3,122

Medicare Intermediary cms

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: n/a Fiscal Year: 11/30

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	282,045	19,042	7,225	308,312		308,312		308,312			1
2	Food Purchase		280,429		280,429	(30,000)	250,429	(19,323)	231,106			2
3	Housekeeping	204,200	44,504		248,704		248,704		248,704			3
4	Laundry	69,135	14,411		83,546		83,546		83,546			4
5	Heat and Other Utilities			177,622	177,622		177,622	(3,754)	173,868			5
6	Maintenance	73,603	64,697	2,400	140,700		140,700		140,700			6
7	Other (specify):*											7
8	TOTAL General Services	628,983	423,083	187,247	1,239,313	(30,000)	1,209,313	(23,077)	1,186,236			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	2,081,072	166,012	7,612	2,254,696		2,254,696	(35,370)	2,219,326			10
10a	Therapy	28,882	130,479	598,816	758,177	(729,295)	28,882		28,882			10a
11	Activities	59,591	9,693		69,284		69,284		69,284			11
12	Social Services	91,204	3,935	3,130	98,269		98,269		98,269			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,260,749	310,119	622,558	3,193,426	(729,295)	2,464,131	(35,370)	2,428,761			16
	C. General Administration											
17	Administrative	70,687	3,500	40,003	114,190		114,190		114,190			17
18	Directors Fees											18
19	Professional Services			63,385	63,385		63,385		63,385			19
20	Dues, Fees, Subscriptions & Promotions			50,476	50,476		50,476	(27,783)	22,693			20
21	Clerical & General Office Expenses	104,407	20,060		124,467		124,467		124,467			21
22	Employee Benefits & Payroll Taxes			751,932	751,932	30,000	781,932	17,000	798,932			22
23	Inservice Training & Education			4,685	4,685		4,685		4,685			23
24	Travel and Seminar			5,666	5,666		5,666		5,666			24
25	Other Admin. Staff Transportation		2,782		2,782		2,782		2,782			25
26	Insurance-Prop.Liab.Malpractice			53,440	53,440		53,440		53,440			26
27	Other (specify):*											27
28	TOTAL General Administration	175,094	26,342	969,587	1,171,023	30,000	1,201,023	(10,783)	1,190,240			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,064,826	759,544	1,779,392	5,603,762	(729,295)	4,874,467	(69,230)	4,805,237			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			176,532	176,532		176,532		176,532			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			176,532	176,532		176,532		176,532			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					729,295	729,295		729,295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		6,806		6,806		6,806	(6,806)				41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		6,806	58,035	64,841	729,295	794,136	(6,806)	787,330			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,064,826	766,350	2,013,959	5,845,135		5,845,135	(76,036)	5,769,099			45

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

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	(19,323)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,754)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,965)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,818)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,860)		\$	30

BHF USE ONLY							
48		49		50		51	

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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (50,860)		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	special services see page 16	x		598,816	10a	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology			37,053	10a	42
43	Prescription Drugs			93,426	10a	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 729,295		47

ID#0005009

Report Period Beginning:12/01/2010

Ending:11/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	cost recovery of medical supplies solt to residents	\$ (35,370)	10	1
2				2
3	coffee and gift shop	(6,806)	41	3
4				4
5	health insurance costs	17,000	22	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	(25,176)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home of Menard County # 0005009 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(19,323)	0	0	0	0	0	0	0	0	0	0	(19,323)	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	(3,754)	0	0	0	0	0	0	0	0	0	0	(3,754)	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	(23,077)	0	0	0	0	0	0	0	0	0	0	(23,077)	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	(35,370)	0	0	0	0	0	0	0	0	0	0	(35,370)	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	(35,370)	0	0	0	0	0	0	0	0	0	0	(35,370)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(27,783)	0	0	0	0	0	0	0	0	0	0	(27,783)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	17,000	0	0	0	0	0	0	0	0	0	0	17,000	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(10,783)	0	0	0	0	0	0	0	0	0	0	(10,783)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,230)	0	0	0	0	0	0	0	0	0	0	(69,230)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Acres Nursing Home of Menard County # 0005009 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	(6,806)	0	0	0	0	0	0	0	0	0	0	(6,806)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(6,806)	0	0	0	0	0	0	0	0	0	0	(6,806)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(76,036)	0	0	0	0	0	0	0	0	0	0	(76,036)	45

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.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Menard County, Illinois	100%	none		Country Estates	Petersburg, Illinois	independent
				Of the County		living facility
				totally owned by		
				Menard County		
				Sunny Acres		
				Nursing Home		

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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating 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.

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	Menard County	100%	None		None			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
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16								16
17								17
18								18
19								19
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$ none		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	\$ none		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 Sunny Acres Nursing Home of Menard County # 0005009 Report Period Beginning: 12/01/2010 Ending: 1/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	none						\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	none											6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10	none											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		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.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	none	8	
		2007	none	9	
		2008	none	10	
		2009	none	11	
		2010	none	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.

FACILITY NAME	<u>Sunny Acres Nursing Home of Menard County</u>	COUNTY	<u>Menard</u>
---------------	--	--------	---------------

COUNTY Menard

TELEPHONE () FAX #: ()

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.

B. Real Estate Tax Cost Allocations

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.)

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,190

B. General Construction Type: Exterior brick Frame protected noncombust Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

Countryside Estates of the County is an independent living facility located adjacent to Sunny Acres Nursing Home. The financial operations of Countryside Estates of the County are accounted for in a separate and distinct Menard County fund, as are the financial operations of Sunny Acrtes Nursing Home. Menard County issued revenue bonds in April, 1998 through the Sunny Acres Nursing Home Fund to partially finance the construction of the facility for the operation of Countryside Estates of the County. That portion of the facility's construction costs not financed with the revenue bonds' proceeds was financed with funds provided by the Sunny Acres Nursing Home Fund in the amount of \$1,071,628.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	County owned land that the nursing home			\$ 25,000	1
2	and independent living facility are situated on				2
3	TOTALS			\$ 25,000	3

Facility Name & ID Number Sunny Acres Nursing Home of Menard County

0005009

Report Period Beginning:

12/01/2010 Ending: 11/30/2011

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	58		1966	1966	\$ 526,787	\$	40	\$		\$ 526,787	4
5	38		1977	1977	568,714	14,218	40	14,218		483,411	5
6			1984	1984	61,842	2,061	30	2,061		56,682	6
7	10		1993	1993	654,160	16,354	40	16,354		297,098	7
8			1995	1995	68,999	3,450	20	3,450		55,200	8
	Improvement Type**										
9	generator			1980	28,901		10			28,901	9
10	fire alarm system			1981	9,805		10			9,805	10
11	none			1982							11
12	gazebo and floor coverings			1983	12,750		20-23			12,750	12
13	flooring, phone, and paging systems, air conditioner			1984	30,885		10-25			30,885	13
14	sun room, remodelling, wall paper			1985	7,061		5-30			7,061	14
15	kitchen remodelling, wallpaper, parking lot, nightlight, etc			1986	36,333		5-25			36,333	15
16	boiler repair, sprinkler system, office remodelling			1987	17,193		5-25			17,193	16
17	roof, chimney, carpeting, sprinkler system			1988	147,826		5-25			147,826	17
18	compressor, canopy, carport			1989	6,472		15			6,472	18
19	asbestos removal, flooring, water heater, landscaping, canopy			1990	28,642		5-15			28,642	19
20	main air conditioning unit			1991	5,194		15			5,194	20
21	none			1992							21
22	new lagoon, tiling, hot wate heater, aviary			1993	223,851		13			223,851	22
23	fill old lagoon, flooring, wallpaper, and signs			1994	49,671		12			49,671	23
24	major boiler repair, air conditioners, ceiling tile replacement			1995	10,685		5-10			10,685	24
25	special needs unit, resident walking gardens, vinyl soffets			1996	139,517	17,674	5-30	17,674		89,746	25
26	donor recognition,wall, remodelling, draperies, and shades			1997	20,798		5-10			20,798	26
27	major boiler repair, air conditioners, ceiling tile replacement			1998	21,699		5			21,699	27
28	two commercial water hearters, entrybath, rooftop			1999	41,844		7-10			37,885	28
29	plumbing, improvements, stuctural improvements			2000	18,896		5			18,896	29
30	plumbing, electrical, boiler rehabilitation			2001	22,162		5			22,162	30
31	structural improvements, sewer lines and walls			2002	77,846	5,618	10-15	5,618		51,498	31
32	seal parking lot, fences improvements			2003	16,153	1,066	5-10	1,066		14,454	32
33	flooring, alarm systems, office remodelling			2004	67,361	5,532	10-20	5,532		41,561	33
34	kitchen tile and ceiling, carpeting, drapes, circuit improvements			2005	17,158	1,715	10	1,715		11,148	34
35	entrance improvements, wiring cable system, front doors			2006	45,926	5,146	10-20	5,146		27,063	35
36	carpeting, vinyl flooring			2007	13,077	1,868	7	1,868		8,406	36

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

See Page 12A, Line 70 for total

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

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	sprinkler system in progress	2007	\$ 6,128	\$ 409		\$ 409		\$ 1,877	37
38	front walk and handrails	2007	19,000	950		950		4,199	38
39	hot water heater	2007	3,823	546		546		2,321	39
40	foam roofing system	2007	141,519	7,076		7,076		30,073	40
41	draft inducer and heater	2007	4,577	654		654		3,106	41
42	lockinvar water heater	2007	5,292	3,024		3,024		6,048	42
43	extend sprinkler system	2008	169,566	8,478		8,478		28,260	43
44	replace boiler and cooling system	2009	388,232	25,882		25,882		66,862	44
45	alarm system for building	2009	30,000	2,000		2,000		4,333	45
46	bath entry	2009	5,460	546		546		1,320	46
47	back flow preventer	2009	3,602	515		515		1,116	47
48	vinyl flooring	2009	3,406	681		681		1,646	48
49	frame up pictures	2009	3,842	768		768		2,176	49
50	air unit compressor	2009	4,447	889		889		2,074	50
51	office improvements	2010	4,491	50		50		100	51
52	vinyl floor replacement	2011	9,594	959	5	959		959	52
53	window replacement	2011	128,150	582	20	582		582	53
54	soffets ans facia replacement	2011	39,732		20				54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,969,069	\$ 128,711		\$ 128,711	\$	\$ 2,556,815	70

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

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	\$362,403	\$33,062	\$33,062		3-20	\$188,115	71
72	Current Year Purchases	110,732	7,646	7,646		4-7	7,646	72
73	Fully Depreciated Assets	764,000	3,657	3,657		5-20	764,000	73
74								74
75	TOTALS	\$1,237,135	\$44,365	\$44,365			\$959,761	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	facility operations	1989 van	1989	\$22,320				5	\$22,320	76
77	facility operations	2006 ford supreme van	2006	44,625	2,231	2,231		4	44,625	77
78	facility operations	pickup truck	2006	6,120	1,225	1,225		5	3,876	78
79										79
80	TOTALS			\$73,065	\$3,456	\$3,456			\$70,821	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,279,26981
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$176,53282
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$176,53283
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)	\$3,587,39785

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: not applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ 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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☒ NO 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	\$	\$	\$	\$ none
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		hrs	\$		\$ 247,141	\$ 51,899		\$ 299,040	1
2	Licensed Speech and Language Development Therapist		hrs			123,506	25,936		149,442	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			228,169	52,644		280,813	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$ 598,816	\$ 130,479		\$ 729,295	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 466,997	\$ 922,417	1
2	Cash-Patient Deposits	201,811	209,061	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 49,913)	1,309,336	1,310,130	3
4	Supply Inventory (priced at Fifo)	18,000	21,517	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,250	3,250	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,999,394	\$ 2,466,375	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,702,691		12
13	Land			13
14	Buildings, at Historical Cost	3,969,069	6,345,190	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,310,199	1,401,962	16
17	Accumulated Depreciation (book methods)	(3,587,396)	(4,803,597)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,345,258	2,345,258	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,739,821	\$ 5,288,813	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,739,215	\$ 7,755,188	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 244,297	\$ 253,020	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	201,811	209,061	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	155,429	155,429	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 601,537	\$ 617,510	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 601,537	\$ 617,510	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,137,678	\$ 7,137,678	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,739,215	\$ 7,755,188	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,675,700	1
2	Restatements (describe):		2
3	restatement of 11-30-10 accounts receivable carrying value	(15,763)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,659,937	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	537,741	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)	\$ 537,741	17
	B. Transfers (Itemize):		
18	return of capital to the general fund	(60,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (60,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,137,678	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunny Acres Nursing Home of Menard County

0005009

Report Period Beginning: 12/01/2010

Ending: 11/30/2011

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**

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,228,221	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,228,221	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	10,205	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	19,323	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,529	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)	\$ 65,057	23
	D. Non-Operating Revenue		
24	Contributions	22,516	24
25	Interest and Other Investment Income***	67,082	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 89,598	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,382,876	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,239,313	31
32	Health Care	3,193,426	32
33	General Administration	1,171,023	33
	B. Capital Expense		
34	Ownership	176,532	34
	C. Ancillary Expense		
35	Special Cost Centers	6,806	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,845,135	40
41	Income before Income Taxes (line 30 minus line 40)**	537,741	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 537,741	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 Sunny Acres Nursing Home of Menard County

0005009

Report Period Beginning:

12/01/2010

Ending:

11/30/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,913	2,162	\$ 65,284	\$ 30.20	1
2	Assistant Director of Nursing	31	50	1,344	26.88	2
3	Registered Nurses	7,142	7,814	184,584	23.62	3
4	Licensed Practical Nurses	29,625	36,934	720,996	19.52	4
5	CNAs & Orderlies	78,608	93,828	1,049,332	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	788	885	11,444	12.93	9
10	Activity Assistants	4,071	4,898	48,147	9.83	10
11	Social Service Workers	5,623	6,242	91,204	14.61	11
12	Dietician					12
13	Food Service Supervisor	880	880	13,171	14.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,177	5,849	67,685	11.57	15
16	Dishwashers	20,707	22,668	201,189	8.88	16
17	Maintenance Workers	5,768	6,501	73,603	11.32	17
18	Housekeepers	18,635	20,363	204,200	10.03	18
19	Laundry	7,415	7,997	69,135	8.65	19
20	Administrator	1,795	1,858	70,687	38.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,820	2,026	43,938	21.69	23
24	Clerical	4,687	5,476	60,469	11.04	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)	1,625	1,821	28,882	15.86	30
31	Medical Records					31
32	Other Health Care(specify)	3,764	4,466	59,532	13.33	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,074	232,718	\$ 3,064,826 *	\$ 13.17	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	105	\$ 7,225	1&3	35
36	Medical Director	130	13,000	9&3	36
37	Medical Records Consultant	32	1,760	10&3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	146	5,852	10&3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	33	3,130	12&3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	446	\$ 30,967		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	none	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ none		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Patricia McNeal	adminiatorator	none	\$ 70,687
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,687
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
Michael J. Feriozzi C.P.A.	audit and accounting		\$ 22,200
Revere Healthcare LTD	financial consulting		36,915
Administrative Services	cafeteria plan administration		4,270
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 63,385
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 153,820
Unemployment Compensation Insurance			4,392
FICA Taxes			231,364
Employee Health Insurance			128,102
Employee Meals			30,000
Illinois Municipal Retirement Fund (IMRF)*			251,254
TOTAL (agree to Schedule V, line 22, col.8)			\$ 798,932
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
none			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 3,980
Advertising: Employee Recruitment			39,255
Health Care Worker Background Check			1,728
(Indicate # of checks performed 64)			3,747
Patient Background Checks	109		1,766
Less: Public Relations Expense			(4,495)
Non-allowable advertising			(15,470)
Yellow page advertising			(7,818)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,693
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$ 0
In-State Travel			4,761
Seminar Expense			905
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 5,666

*** Attach copy of IMRF notifications**

****See instructions.**

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	none		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IHCA 5,933 INHA 100.
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,443 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,035
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? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 30,000 Has any meal income been offset against related costs? yes Indicate the amount. \$ 19,323
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 99%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Mr. Michael J. Feriozzi C.P.A.
- (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

Section V, Part B, Line 10(a) column 5

The amount, 729,295 is the total of ancillary costs from page 16

Schedule XV, balance sheet, explanation of consolidation column

The consolidation presents Sunny Acres Nursing Home and its investment in Countryside Estates of the County
The financial reporting entity is discussed in the notes to the audited financial statements for Sunny Acres Nursing Home for the year ended November 30, 2011.

Schedule XVII, income statement, line 25 interest and other investment income

interest income	18,841
nursing home's increase in its investment in its wholly owned independent living facility reported using the equity method of accounting	<u>48,241</u>
	<u><u>67,082</u></u>

Schedule XIX SUPPORT SCHEDULES G. Schedule of travel and seminar

"In state travel" consists of mileage reimbursements to employees
for attending courses and seminars. Individual reimbursements of \$150 or less.

"Seminar expense" consists of fees and costs of instructional materials for employees attending
courses and seminars. Individual amounts less than \$350.

page 23, XX General information

the independent audit is still in process, audited financial statements will be provided at a later date.
the final audited financial statements will be provided by April 30, 2012.