

		FOR BHF USE					

LL1

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: <u>0014076</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Sunny Hill Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/10</u> to <u>11/30/11</u> 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.																																															
Address: <u>421 Doris Avenue</u> <u>Joliet</u> <u>60433</u>																																																	
Number City Zip Code																																																	
County: <u>Will</u>																																																	
Telephone Number: <u>(815) 727-8710</u> Fax # <u>(815) 727-8637</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																																				
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Date of Initial License for Current Owners: <u>1955</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☒</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☒</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☒	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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		☐	Limited Liability Co.																																														
		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:		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																																															
Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Sunny Hill Nursing Home

0014076 Report Period Beginning: 12/1/10 Ending: 11/30/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	280	107,420	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	300	TOTALS	280	107,420	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	57,812	11,710	8,515	78,037	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,812	11,710	8,515	78,037	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.65%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES X NO ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location? Date started 1972

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

K. Was the facility certified for Medicare during the reporting year? YES X NO ☐ If YES, enter number of beds certified 280 and days of care provided 8,515

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 11/30/11 Fiscal Year: 11/30/11

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

Sunny Hill Nursing Home
FYE: 11/30/11
Medicaid Cost Report Workpapers
Provider Number - 0014076

Schedule 2A

Bed Days Calculation

		# of Days	# of Days	Bed Days Available
		12/01/10 - 8/28/11	12/01/10 - 108/28/11	
Skilled (SNF)	300	261	0	78,300
Skilled (SNF)	280	-	104	29,120
TOTAL BED DAYS AVAILABLE				107,420

Facility Name & ID Number Sunny Hill Nursing Home # 0014076 Report Period Beginning: 12/1/10 Ending: 11/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	761,194	49,283	20,115	830,592		830,592		830,592			1
2	Food Purchase		538,186		538,186		538,186	(4,405)	533,781			2
3	Housekeeping	755,218	94,675		849,893		849,893		849,893			3
4	Laundry	200,754	70,996		271,750		271,750		271,750			4
5	Heat and Other Utilities			268,101	268,101		268,101		268,101			5
6	Maintenance		2,671	120,215	122,886		122,886	742,088	864,974			6
7	Other (specify):*											7
8	TOTAL General Services	1,717,166	755,811	408,431	2,881,408		2,881,408	737,683	3,619,091			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	6,809,783	509,525	455,206	7,774,514		7,774,514	(23,910)	7,750,604			10
10a	Therapy	216,301	12,635	896,314	1,125,250		1,125,250		1,125,250			10a
11	Activities	259,872			259,872		259,872		259,872			11
12	Social Services	291,934			291,934		291,934		291,934			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,577,890	522,160	1,356,520	9,456,570		9,456,570	(23,910)	9,432,660			16
	C. General Administration											
17	Administrative	187,544			187,544		187,544		187,544			17
18	Directors Fees											18
19	Professional Services			60,738	60,738		60,738	1,092,755	1,153,493			19
20	Dues, Fees, Subscriptions & Promotions			41,545	41,545		41,545	(19,986)	21,559			20
21	Clerical & General Office Expenses	323,272	34,520	35,002	392,794		392,794	76,034	468,828			21
22	Employee Benefits & Payroll Taxes			4,896,991	4,896,991		4,896,991	579,213	5,476,204			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,338	2,338		2,338		2,338			24
25	Other Admin. Staff Transportation			2,196	2,196		2,196		2,196			25
26	Insurance-Prop.Liab.Malpractice							452,939	452,939			26
27	Other (specify):*											27
28	TOTAL General Administration	510,816	34,520	5,038,810	5,584,146		5,584,146	2,180,955	7,765,101			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,805,872	1,312,491	6,803,761	17,922,124		17,922,124	2,894,728	20,816,852			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			486,373	486,373		486,373		486,373			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,468	1,468		1,468	(1,468)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,027	1,027		1,027		1,027			34
35	Rent-Equipment & Vehicles			39,763	39,763		39,763		39,763			35
36	Other (specify):*											36
37	TOTAL Ownership			528,631	528,631		528,631	(1,468)	527,163			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,438		207,438		207,438		207,438			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):* Non-Allow Costs			9,068	9,068		9,068	(9,068)				43
44	TOTAL Special Cost Centers		207,438	173,318	380,756		380,756	(9,068)	371,688			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,805,872	1,519,929	7,505,710	18,831,511		18,831,511	2,884,192	21,715,703			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	(4,405)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,906)	20		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	(1,468)	32		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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,391)	20		28
29	Other-Attach Schedule See Pg 5A	(37,667)	Vari		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,837)		\$	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)	2,943,029		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,943,029		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,884,192		37

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

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

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

Report Period Beginning:

Ending:

ID#

0014076

12/1/10

11/30/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Chamber of Commerce Dues	\$ (395)	20	1
2	Lab Services	(7,600)	43	2
3	Disallow IHCA PAC Dues	(4,294)	20	3
4	Disallow non-allowable radiology services	(23,910)	10	4
5	Disallow non-allowable late fees	(1,468)	43	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
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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	(37,667)		49

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
Will County	100%	N/A		Will County	Joliet	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	\$	Will County	100.00%	\$ 742,088	\$ 742,088	1
2	V	19	Professional Services		Will County	100.00%	1,092,755	1,092,755	2
3	V	21	Film Processing		Will County	100.00%	23,674	23,674	3
4	V	21	Telephone		Will County	100.00%	52,360	52,360	4
5	V	22	Employee Benefits		Will County	100.00%	579,213	579,213	5
6	V	26	Insurance		Will County	100.00%	452,939	452,939	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 2,943,029	\$ * 2,943,029	14

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	See attached list of	County board									3
4	board members	member	Administrative	0.00	None	<1 hour	0.00	N/A	None	N/A	4
5	No services have been provided to the nursing home by board members										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 Sunny Hill Nursing Home # 0014076 Report Period Beginning: 12/1/10 Ending: 11/30/11

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 Will County
Street Address 302 North Chicago
City / State / Zip Code Joliet, IL 60432
Phone Number (815) 740-4607
Fax Number (815) 740-4319

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance	% of Staff	N/A	1	\$ 742,088	\$	1	\$ 742,088	1
2	19	Professional Services	% Hours / % Warrants	N/A	1	1,092,755		1	1,092,755	2
3	21	Film Processing	% State	N/A	1	23,674		1	23,674	3
4	21	Telephone	% Hours / % Warrants	N/A	1	52,360		1	52,360	4
5	22	Employee Benefits	% Employees	N/A	1	579,213		1	579,213	5
6	26	Insurance	% Employees	N/A	1	452,939		1	452,939	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					\$ 2,943,029	\$		\$ 2,943,029	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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Various		X	Finance Charges								1,468	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 1,468	9
	B. Non-Facility Related*												
10								Less: Non-Allowable Finance Charges				(1,468)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (1,468)	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. \$ N/A Line # N/A

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

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

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.	\$	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.)		2010	\$	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 8 2007 9 2008 10 2009 11 2010 12	FOR BHF USE ONLY	
Not applicable - county does not pay real estate taxes.			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 Sunny Hill Nursing Home COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Karen Sobero, Administrator

TELEPHONE (815) 727-8710 FAX #: (815) 727-8637

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)		(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>		<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	N/A - County does not pay real estate taxes.		\$ _____	\$ _____
2.			\$ _____	\$ _____
3.			\$ _____	\$ _____
4.			\$ _____	\$ _____
5.			\$ _____	\$ _____
6.			\$ _____	\$ _____
7.			\$ _____	\$ _____
8.			\$ _____	\$ _____
9.			\$ _____	\$ _____
10.			\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

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?

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 116,410

B. General Construction Type: Exterior BrickFrame Steel/Concrete BlockNumber of Stories Two

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs: N/A

(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	Resident Care		1972	\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		1972	1972	\$ 1,375,843	\$ 34,396	40	\$ 34,396	\$	\$ 1,370,106	4
5	150		1976	1976	1,198,083	29,952	40	29,952		1,063,296	5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing		1970		727		20			727	9
10	Landscaping		1972		51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance		1973		37,155		10-20			37,155	11
12	Door		1974		38,466		20			38,466	12
13	Asphalt Paving		1975		155,856		15			155,856	13
14	Landscaping		1976		57,254		10-15			57,254	14
15	Sewer and Water		1976		26,031		30			26,031	15
16	Plumbing		1972		183,817		25			183,817	16
17	Heating and Electrical		1972		522,443		20			522,443	17
18	Plumbing		1976		262,534		25			262,534	18
19	Heating and Electrical		1976		508,942		20			508,942	19
20	Sprinkler System and Paving		1975		83,460		25			83,460	20
21	Repairs / Roof		1981		107,858		15			107,858	21
22	Building Improvement		1987		819,813	32,792	25	32,792		803,406	22
23	Reroof A & B Roof		1985		85,920		20			85,920	23
24	Parking Lot Lights		1989		3,040		15			3,040	24
25	Reroof / Hot Water		1992		162,867	8,143	20	8,143		158,789	25
26	Washer Repair		1992		3,284		3			3,284	26
27	Site Improvements		1993		101,451		15			101,451	27
28	Laundry Renovation		1994		108,852		15			108,852	28
29	Paving Parking Lot		1995		66,260		15			66,260	29
30	Laundry, Air Conditioner		1996		362,815		12			362,815	30
31	Elevator Repair		1997		4,990		10			4,990	31
32	Tile		1992		7,040		5			7,040	32
33	Elevator Repair		1996		2,212		3			2,212	33
34	Sheeting		1993		3,685		3			3,685	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Hill Nursing Home

0014076

Report Period Beginning:

12/1/10

Ending:

11/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Site improvement	1998	\$ 2,936	\$	10	\$	\$	\$ 2,936	37
38	Electrical work	1998	2,085		10			2,085	38
39	Plumbing repair	1998	2,440		10			2,440	39
40	Boiler repair	1998	4,273		10			4,273	40
41	Fence	1999	1,000		10			1,000	41
42	Air Conditioning Repair	1999	6,284		10			6,284	42
43	Boiler repair	1999	4,965		10			4,965	43
44	Doors	1999	4,842		10			4,842	44
45	Carpeting	1999	1,649		10			1,649	45
46	Nurses Station	1999	53,554		10			53,554	46
47	Wallpaper	2000	840		10			840	47
48	Vinyl Board	2000	823		10			823	48
49	Office Compressor	2000	1,205		10			1,205	49
50	Fire System	2000	3,441		10			3,441	50
51	Fence	2000	936		10			936	51
52	Air Ducts	2000	3,090		10			3,090	52
53	Service Work	2000	1,573		10			1,573	53
54	Parking Lot	2000	4,860		10			4,860	54
55	Circular Pumps	2000	1,079		10			1,079	55
56	Boiler repair	2001	5,326	263	10	263		5,326	56
57									57
58	Plumbing	2002	11,756	1,176	10	1,176		11,172	58
59	Air Cleaner	2002	2,020	202	10	202		1,919	59
60	Boiler	2002	5,658	567	10	567		5,386	60
61	HVAC Control	2002	2,800	280	10	280		2,660	61
62	Fire and Smoke Dampers	2002	26,087	2,609	10	2,609		24,785	62
63	Doors	2002	4,155	416	10	416		3,952	63
64	Fireproof Framing	2002	2,730	273	10	273		2,594	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,504,680	\$ 111,069		\$ 111,069	\$	\$ 6,340,933	70

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

Facility Name & ID Number Sunny Hill Nursing Home

0014076

Report Period Beginning:

12/1/10

Ending:

11/30/11

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		\$ 6,504,680	\$ 111,069		\$ 111,069	\$	\$ 6,340,933	1
2	HVAC	2003	11,370	1,137	10	1,137		9,665	2
3	Plumbing	2003	11,833	1,183	10	1,183		10,056	3
4	Oven repairs	2003	3,020	302	10	302		2,567	4
5	Dishwasher repairs	2003	1,419	142	10	142		1,207	5
6	Garbage disposal	2003	2,429	243	10	243		2,065	6
7	Freezer doors	2003	5,610	561	10	561		4,769	7
8	Boiler repairs	2003	21,892	2,189	10	2,189		18,607	8
9	Entrance door repairs	2003	13,240	1,324	10	1,324		11,254	9
10	Washing machine repair	2003	1,045	105	10	105		892	10
11	Site improvement	2003	8,252	825	10	825		7,013	11
12									12
13	Fire alarm system	2004	140,676	14,068	10	14,068		105,510	13
14	Water pipes replaced	2004	44,498	4,450	10	4,450		33,375	14
15	Structural work	2004	5,331	534	10	534		4,005	15
16	Windows	2004	29,590	2,960	10	2,960		22,200	16
17	Wall divider	2004	11,280	1,128	10	1,128		8,460	17
18	Front gate and posts	2004	8,025	802	10	802		6,015	18
19									19
20	Various lighting	2005	60,791	6,080	10	6,080		39,520	20
21	Cabinet	2005	1,200	120	10	120		780	21
22	Cabinet	2005	4,900	490	10	490		3,185	22
23	Pavement	2005	6,581	658	10	658		4,277	23
24	Stump removal and excavation	2005	12,600	1,260	10	1,260		8,190	24
25	Fire alarm modification	2005	4,286	428	10	428		2,782	25
26		2005	23,365	2,336	10	2,336		15,184	26
27	Remove & Replace concrete sidewalk for								27
28	front entrance to facility	2008	7,059	706	10	706		2,471	28
29									29
30	Remove & Replace doors	2009	15,489	3,098	5	3,098		6,970	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,960,461	\$ 158,198		\$ 158,198	\$	\$ 6,671,952	34

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

Facility Name & ID Number Sunny Hill Nursing Home

0014076

Report Period Beginning:

12/1/10

Ending:

11/30/11

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 12B, Carried Forward		\$ 6,960,461	\$ 158,198		\$ 158,198	\$	\$ 6,671,952	1
2	1st Floor F-Wing	2009	3,215,133	80,378	40	80,378		200,945	2
3	- General Conditions								3
4	- Insurance								4
5	- OH&P								5
6	- Demolition, Asbestos removal								6
7	- Asbestos Abatement								7
8	- Materials (Steel)								8
9	- Rough Carpentry								9
10	- Millwork, Casework & Materials								10
11	- Caulking								11
12	- HM Doors & Hardware								12
13	- Glass & Glazing								13
14	- Windows, Installation & Trim								14
15	- Finish Carpentry								15
16	- Floor Cover, Demo, Patch								16
17	- Painting, Wall Coverings, Tape								17
18	- Toilet hardware & Accessories								18
19	- Cubical Curtains								19
20	- Signage								20
21	- Fire Extinguishers								21
22	- Sprinkler System								22
23	- Plumbing Demo								23
24	- Plumbing								24
25	- HVAC								25
26	- Electrical								26
27	- Contingency								27
28	- Contingency								28
29									29
30	Generator	2009	528,400	13,210	40	13,210		33,025	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,703,994	\$ 251,786		\$ 251,786	\$	\$ 6,905,922	34

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

Facility Name & ID Number Sunny Hill Nursing Home

0014076

Report Period Beginning:

12/1/10

Ending:

11/30/11

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 12C, Carried Forward		\$ 10,703,994	\$ 251,786		\$ 251,786	\$	\$ 6,905,922	1
2	Lower Level E-Wing, Main Entrance & Canopy	2009	3,669,058	91,726	40	91,726		229,315	2
3	- General Conditions								3
4	- Insurance								4
5	- OH&P								5
6	- Demolition, Asbestos removal								6
7	- Asbestos Abatement								7
8	- Rough Carpentry								8
9	- Millwork, Casework & Materials								9
10	- Roofing								10
11	- Caulking								11
12	- HM Doors & Hardware								12
13	- Windows & Glazing								13
14	- Finish Carpentry								14
15	- Floor Coverings								15
16	- Painting, Wall Coverings, Tape								16
17	- Toilet hardware & Accessories								17
18	- Cubical Curtains								18
19	- Signage								19
20	- Fire Extinguishers								20
21	- Sprinkler System								21
22	- Plumbing Demo & Concrete								22
23	- Plumbing								23
24	- HVAC								24
25	- Electrical								25
26	- Contingency								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,373,052	\$ 343,512		\$ 343,512	\$	\$ 7,135,237	34

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

Facility Name & ID Number Sunny Hill Nursing Home

0014076

Report Period Beginning:

12/1/10

Ending:

11/30/11

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 12D, Carried Forward		\$ 14,373,052	\$ 343,512		\$ 343,512	\$	\$ 7,135,237	1
2	1st Floor E-Wing	2009	3,077,955	76,949	40	76,949		192,372	2
3	- General Conditions								3
4	- Insurance								4
5	- OH&P								5
6	- Demolition, Asbestos removal								6
7	- Asbestos Abatement								7
8	- Materials (Steel)								8
9	- Rough Carpentry								9
10	- Millwork, Casework & Materials								10
11	- Caulking								11
12	- HM Doors & Hardware								12
13	- Glass & Glazing								13
14	- Windows, Installation & Trim								14
15	- Finish Carpentry								15
16	- Floor Cover, Demo, Patch								16
17	- Painting, Wall Coverings, Tape								17
18	- Toilet hardware & Accessories								18
19	- Cubical Curtains								19
20	- Signage								20
21	- Fire Extinguishers								21
22	- Sprinkler System								22
23	- Plumbing Demo								23
24	- Plumbing								24
25	- HVAC								25
26	- Electrical								26
27	- Contingency								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,451,007	\$ 420,461		\$ 420,461	\$	\$ 7,327,609	34

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

Facility Name & ID Number Sunny Hill Nursing Home

0014076

Report Period Beginning:

12/1/10

Ending:

11/30/11

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 12E, Carried Forward		\$ 17,451,007	\$ 420,461		\$ 420,461	\$	\$ 7,327,609	1
2	1st Floor E-Wing	2010	57,230	1,431	40	1,431		2,146	2
3	- General Conditions								3
4	- OH&P								4
5	- Asbestos Abatement								5
6	- Rough Carpentry								6
7	- HVAC								7
8	- Electrical								8
9									9
10	Resident Room Remodel	2011	3,070,458	38,381	40	38,381		38,381	10
11	- General Conditions								11
12	- OH&P								12
13	- Asbestos Abatement								13
14	- Rough Carpentry								14
15	- Electrical								15
16	- plumbing								16
17									17
18	Tile floor resurfacing	2011	3,500	350	5	350		350	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,582,195	\$ 460,623		\$ 460,623	\$	\$ 7,368,486	34

**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	\$166,984	\$12,409	\$12,409	\$	5-10	\$81,943	71
72	Current Year Purchases	133,411	13,341	13,341		5	13,341	72
73	Fully Depreciated Assets	2,003,986					2,003,986	73
74								74
75	TOTALS	\$2,304,381	\$25,750	\$25,750	\$		\$2,099,270	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$22,911,576	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$486,373	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$486,373	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)	\$9,467,756	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Storage Unit				1,027			6
7	TOTAL				\$ 1,027			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
- N/A
- N/A

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms: N/A
- *

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: \$ 39,763
- Description: See Attached Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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 Ending	Annual 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.

Sunny Hill Nursing Home
PROVIDER # 0014076
12/01/10 - 11/30/11

Schedule 14A

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

Helium tanks	\$ 1,400
Ice Machine	3,000
Dietary Equipment	8,508
Nursing Equipment	21,098
Oxygen Tanks	5,757
	<u>39,763</u>
	<u>39,763</u>

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

12345678										
	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(2,3)	hrs	\$	6,445	\$ 483,369	\$ 6,837	6,445	\$ 490,206	1
2	Licensed Speech and Language Development Therapist	10A(2,3)	hrs		928	69,589	984	928	70,573	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		4,538	340,351	4,814	4,538	345,165	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				207,438		207,438	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	11,911	\$ 893,309	\$ 220,073	11,911	\$ 1,113,382	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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	14,138,047	14,138,047	15
16	Equipment, at Historical Cost	2,304,381	2,304,381	16
17	Accumulated Depreciation (book methods)	(9,467,756)	(9,467,756)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,443,820	\$ 13,443,820	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,443,820	\$ 13,443,820	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	906,918	906,918	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)	\$ 906,918	\$ 906,918	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)	\$ 906,918	\$ 906,918	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,536,902	\$ 12,536,902	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,443,820	\$ 13,443,820	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,726,311	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,726,311	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,065,749)	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)	\$ (6,065,749)	17
	B. Transfers (Itemize):		
18	Interfund Transfers	8,876,340	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 8,876,340	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,536,902	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,891,817	1
2	Discounts and Allowances for all Levels	1,589,029	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,480,846	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,003,017	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,003,017	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	4,405	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,937	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,945	19
20	Radiology and X-Ray	22,092	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 279,379	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Sundry	2,520	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,520	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,765,762	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,881,408	31
32	Health Care	9,456,570	32
33	General Administration	5,584,146	33
	B. Capital Expense		
34	Ownership	528,631	34
	C. Ancillary Expense		
35	Special Cost Centers	216,506	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,831,511	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,065,749)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,065,749)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.
Government Entity - Part of County

*** 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.

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	1,965	2,085	\$ 87,194	\$ 41.82	1
2	Assistant Director of Nursing	2,225	2,449	83,558	34.12	2
3	Registered Nurses	36,298	42,083	1,297,397	30.83	3
4	Licensed Practical Nurses	88,919	99,673	2,455,924	24.64	4
5	CNAs & Orderlies	170,833	191,300	2,885,710	15.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,150	11,280	216,301	19.18	8
9	Activity Director					9
10	Activity Assistants	13,336	14,652	259,872	17.74	10
11	Social Service Workers	10,155	10,667	291,934	27.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	46,796	49,398	761,194	15.41	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	46,913	54,018	755,218	13.98	18
19	Laundry	12,470	14,359	200,754	13.98	19
20	Administrator	1,913	1,966	92,726	47.16	20
21	Assistant Administrator	1,993	2,106	70,271	33.37	21
22	Other Administrative	822	960	24,547	25.57	22
23	Office Manager					23
24	Clerical	13,923	15,479	323,272	20.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	458,711	512,475	\$ 9,805,872 *	\$ 19.13	34

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	Monthly	\$ 20,115	1(3)	35
36	Medical Director	Monthly	5,000	9(3)	36
37	Medical Records Consultant	Monthly	676	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,393	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	3,005	10A(3)	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 39,189		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	70	\$ 3,302	10(3)	50
51	Licensed Practical Nurses	3,424	148,767	10(3)	51
52	Certified Nurse Assistants/Aides	10,770	268,158	10(3)	52
53	TOTAL (lines 50 - 52)	14,264	\$ 420,227		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberSunny Hill Nursing Home# 0014076Report Period Beginning: 12/1/10Ending: 11/30/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Sobero	Administrator	0	\$ 92,726
Becky Halderson	Asst. Administrator	0	70,271
Ellen Gerard	Other Administrative	0	24,547
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 187,544

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	\$ 17,050
Media One	Computer Services	74
UHC/Accu-Med Services, Inc.	Medical Billing	12,435
Health Data Systems	Medical Billing	11,713
Symantec	Computer Services	999
Comcast	Computer Services	8
IVANS	Medical Billing	2,687
Medifax - EDI	Medical Billing	1,022
McGladrey & Pullen LLP	Accounting	12,750
FR&R Healthcare	Accounting	2,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 60,738

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$
Unemployment Compensation Insurance	
FICA Taxes	746,719
Employee Health Insurance	2,943,715
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,131,528
Uniforms	65,940
Employee Physicals/Drug Screenings	9,089
Allocation from County - Worker's Comp	579,213
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 140)	1,680
Patient Background Checks 141	1,692
Illinois Healthcare Association	12,144
Miscellaneous Dues & Subscriptions	6,357
Chamber Dues	395
Yellow Page Advertising	4,391
Less: PAC Dues	(4,294)
Less: Public Relations Expense	(395)
Non-allowable advertising (	
Yellow page advertising	(4,391)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
N/A	
In-State Travel	
N/A	
Seminar Expense	
See Attached Schedule	2,338
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,338

* Attach copy of IMRF notifications

**See instructions.

Sunny Hill Nursing Home
Provider #: 0014076
12/1/10 - 11/30/11

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Subtotal	60,738
Total (agree to Schedule V, line 19, column 3)	<u>60,738</u>
Allocated from Will County	1,092,755
Total (agree to Schedule V, line 19, column 8)	<u><u>1,153,493</u></u>

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

IHCA - \$12,144

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 yrs.

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 186,609

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.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 164,250

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.
- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 4,405

(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.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Baker Tilly

(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?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.