

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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

Address: 19130 Sunny Acres Rd Petersburg 62675

NumberCityZip Code

County: Menard

Telephone Number: 217-632-2334 Fax # ()

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: Daniel CurryTelephone Number: 309-823-7164

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 12/01/2024 to 11/30/2025 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) Daniel Curry

(Title) EVP & CFO

(Signed)

(Date)

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12/01/2024 Ending: 11/30/2025

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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	7,801	8,159	5,280	25	5,309	1,224	1,345	29,143	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,801	8,159	5,280	25	5,309	1,224	1,345	29,143	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 80.65%

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

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

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

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

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 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 certified beds. number of certified beds 99

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number		Sunny Acres Nursing Home				#	0005009	Report Period Beginning:		12/01/2024	Ending:		Page 3 11/30/2025
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	374,237	33,911	9,108	417,256		417,256		417,256			1	
2	Food Purchase		243,156		243,156		243,156		243,156			2	
3	Housekeeping	244,449	40,126		284,575		284,575		284,575			3	
4	Laundry	99,856	17,134		116,990		116,990		116,990			4	
5	Heat and Other Utilities			143,142	143,142		143,142		143,142			5	
6	Maintenance	143,250	116,916	196,028	456,194		456,194		456,194			6	
7	Other (specify):*											7	
8	TOTAL General Services	861,792	451,243	348,278	1,661,313		1,661,313		1,661,313			8	
	B. Health Care and Programs												
9	Medical Director			24,000	24,000		24,000		24,000			9	
10	Nursing and Medical Records	2,490,062	187,948	1,054,027	3,732,037	123,979	3,856,016		3,856,016			10	
10a	Therapy		172,222	51,442	223,664	(216,818)	6,846		6,846			10a	
11	Activities	94,072	7,496		101,568		101,568		101,568			11	
12	Social Services	58,532		5,290	63,822		63,822		63,822			12	
13	CNA Training	5,503			5,503		5,503		5,503			13	
14	Program Transportation											14	
15	Other (specify):*											15	
16	TOTAL Health Care and Programs	2,648,169	367,666	1,134,759	4,150,594	(92,839)	4,057,755		4,057,755			16	
	C. General Administration												
17	Administrative	110,488			110,488		110,488		110,488			17	
18	Directors Fees											18	
19	Professional Services			423,290	423,290		423,290	(1,344)	421,946			19	
20	Dues, Fees, Subscriptions & Promotions			227,181	227,181	(159,600)	67,581	(27,857)	39,724			20	
21	Clerical & General Office Expenses	275,522	33,503	8,882	317,907	(130,825)	187,082		187,082			21	
22	Employee Benefits & Payroll Taxes			936,691	936,691		936,691	(3,987)	932,704			22	
23	Inservice Training & Education			267	267		267		267			23	
24	Travel and Seminar			13,928	13,928		13,928	(8,929)	4,999			24	
25	Other Admin. Staff Transportation											25	
26	Insurance-Prop.Liab.Malpractice			132,887	132,887		132,887		132,887			26	
27	Other (specify):* Lost Resident Items			208,042	208,042		208,042	(205,196)	2,846			27	
28	TOTAL General Administration	386,010	33,503	1,951,168	2,370,681	(290,425)	2,080,256	(247,313)	1,832,943			28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,895,971	852,412	3,434,205	8,182,588	(383,264)	7,799,324	(247,313)	7,552,011			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			245,120	245,120		245,120		245,120			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			13,821	13,821		13,821		13,821			35
36	Other (specify):*											36
37	TOTAL Ownership			258,941	258,941		258,941		258,941			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			489,319	489,319	223,664	712,983		712,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					159,600	159,600		159,600			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			489,319	489,319	383,264	872,583		872,583			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,895,971	852,412	4,182,465	8,930,848		8,930,848	(247,313)	8,683,535			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
5	Telephone, TV & Radio in Resident Rooms				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	(3,987)			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	(9,768)			17
18	Fines and Penalties	(157,196)			18
19	Entertainment	(8,929)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,344)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)			24
25	Fund Raising, Advertising and Promotional	(18,089)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes paid on non resident prop				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (247,313)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (247,313)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	xx		7,332	10a	42
43	Prescription Drugs	xx		172,222	10a	43
44	Hospital Services	xx		44,110	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 223,664		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (9,222)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(48,000)	27	11
12		0	33	12
13		(157,196)	27	13
14		(8,867)	20	14
15		(9,768)	20	15
16		(3,987)	22	16
17		(8,929)	24	17
18		(1,344)	19	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	(247,313)		49

Summary A

11/30/2025

[illegible]

Summary B

11/30/2025

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

[illegible]

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
County Commissioners List Attached		None		None		
(Not for profit Board-No individual						
ownership)						

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

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
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 (continued)

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

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	County Commissioners are not compensated by Sunny Acres								\$		1
2	for their services										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12/01/2024 Ending: 1/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	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													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													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. \$ NA 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.)

B. Real Estate Taxes

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Acres Nursing Home COUNTY Menard

FACILITY IDPH LICENSE NUMBER 0005009

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. None		\$	\$
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? YES NO

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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? [xx] (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? [xx] (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 Acres Nursing Home.

F. List the bed capacity for the building if it differs from the licensed total. Same
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO [xx] If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [xx] 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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2024

Ending:

11/30/2025

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99			1966	\$ 526,787	\$		\$	\$	4
5				1977	568,714					5
6				1984	61,842					6
7				1993	654,160	16,354	40	16,354		7
8				1995	68,999					8
	Improvement Type**									
9	Improvements - 1980 - 2006				1,104,632					9
10	Carpeting, vinyl flooring for resident rooms			2007	13,077					10
11	front walk and handrails			2007	19,000	950	20	950		11
12	hot water heater			2007	3,823					12
13	foam roofing system			2007	141,519	7,076	20	7,076		13
14	draft inducer and heater			2007	4,577					14
15	lockinvar water heater			2007	5,289					15
16	extend sprinkler system			2008	163,627	8,478	20	8,478		16
17	replace boiler and cooling system			2009	387,410		15			17
18	alarm system for building			2009	30,000		15			18
19	bath entry			2009	3,406					19
20	back flow preventer			2009	3,602					20
21	air unit compressor			2009	4,447					21
22	office improvements			2010	4,491	50	15	50		22
23	vinyl floor replacement for resident rooms			2011	9,594					23
24	window replacement			2011	121,198	6,408	20	6,408		24
25	soffets and facia replacement			2011	39,732	1,986	20	1,986		25
26	window replacement			2012	1,263	63	20	63		26
27	100 gallon hot water heater replacement			2012	9,100					27
28	vinyl floor covering for resident rooms			2012	5,205					28
29	emergency generator replacement			2013	222,148	11,276	20	11,276		29
30	sewer waste line improvement			2013	12,980		10			30
31	vinyl floor covering for resident rooms			2013	5,642					31
32	resident rooms and office painting			2014	41,690		10			32
33	flooring for resident rooms			2014	13,141					33
34	magnetic holders and compressor and fans etc			2014	9,859		10			34
35	hard wiring for new IT system			2015	8,935	596	15	596		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 Acres Nursing Home

0005009

Report Period Beginning:

12/01/2024 Ending: 11/30/2025

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	roof replacement	2015	\$ 283,332	\$ 18,889	20	\$ 18,889	\$	\$	37
38	resident room flooring	2015	14,695						38
39	modification of waste and vent piping system - Lily wing	2015	60,369	4,025	15	4,025			39
40	Revamp sewer system	2016	18,185	1,819	10	1,819			40
41	Door replacement	2016	2,842	284	10	284			41
42									42
43	Replace water heater	2017	6,816		7				43
44	Septic Tank replacement	2017	5,419		7				44
45									45
46	Water heater replacements (2)	2018	17,590	2,512	7	2,512			46
47	Ceiling replacement - admin wing	2018	13,476	1,348	10	1,348			47
48	3 inch water regulator	2018	5,824	832	7	832			48
49									49
50	5 ton air handler	2019	7,985		5				50
51	AO Smith water heater	2019	6,017		5				51
52	Replace critical panel circuit	2019	9,555		5				52
53	Install new nurse call system	2019	208,043		5				53
54									54
55	Resurfaced main driveway	2020	5,068		3				55
56	Replaced air handling unit - Kitchen	2020	21,900	3,129	7	3,129			56
57	Constructed outdoor pavillion	2020	26,566	1,328	20	1,328			57
58	Roof Replacement - Tore off (2) sections of roof and installed	2020	351,778	17,589	20	17,589			58
59	a Firestone EPDM 30 year warrantied roofing system								59
60									60
61	Outdoor pavillion - completion	2021	11,975	599	20	599			61
62	Replaced compressor	2021	4,611	922	5	922			62
63	Reconstruct main entrance - remason plus add (2) canopy								63
64	columns	2021	13,400	670	20	670			64
65	Roof Replacement - Tore off (2) sections of roof and installation co	2021	218,229	10,911	20	10,911			65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,583,564	\$ 118,094		\$ 118,094	\$	\$	70

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2024 Ending: 11/30/2025

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	
1	Totals from Page 12A, Carried Forward		\$ 5,583,564	\$ 118,094		\$ 118,094	\$	\$	1
2	Replaced exterior vinyl siding	2022	7,900	527	15	527			2
3	Replaced PTAC units	2022	5,768	1,154	5	1,154			3
4	Replaced compressor - walk-in cooler	2022	3,410	682	5	682			4
5	Updated (9) resident rooms by:	2022	9,909	661	15	661			5
6	Replacing all carpet with vinyl planking								6
7	Painting all room walls								7
8	Installing sound reducing wall insulation								8
9	Replace interior vestibule exit door from Lily wing	2023	2,671	267	10	267			9
10	Resurface main parking lot	2023	9,686	1,937	5	1,937			10
11	Replace existing 4020 fire alarm panel with new 4010	2023	29,652	2,965	10	2,965			11
12	ES unit								12
13	Replaced flooring on the Lilac wing - removed existing carpet	2023	15,942	1,594	10	1,594			13
14	and cove down base; installed new glue down vinyl,								14
15	cove base and patching where needed								15
16									16
17	Replaced flooring and plumbing in Patient Room #12	2024	5,862	586	10	586			17
18	Replaced (2) 100 gallon water heaters in the Laundry	2024	27,803	5,560	5	5,560			18
19	Replaced (3) rooftop (RTU) air conditioning units	2024	38,250	3,825	10	3,825			19
20	Replaced water heater and expansion tank	2024	11,985	2,397	5	2,397			20
21	Install new hydrants and extensions	2024	22,588	2,259	10	2,259			21
22	Demolished (5) shower rooms (including asbestos abatement)	2024	279,612	18,640	15	18,640			22
23	and installed new plumbing, fixtures and flooring								23
24									24
25	Installed new refrigeration in cooler and freezer	2025	25,500	1,700	15	1,700			25
26	Replaced generator transfer switch	2025	7,152	477	10	477			26
27	Installed new washer and base (laundry)	2025	13,625	681	10	681			27
28	Replaced existing old fire alarm units (18 smoke detectors	2025	15,086	251	10	251			28
29	and 3 pull stations)								29
30	Replaced roof shingles - storage area	2025	9,527	212	15	212			30
31	Replaced (8) PTAC units - resident rooms	2025	5,942	297	5	297			31
32	Replaced rooftop HVAC unit (#6) with new 7.5 ton	2025	19,480	649	15	649			32
33	gas/electric packaged unit								33
34	TOTAL (lines 1 thru 33)		\$ 6,150,914	\$ 165,415		\$ 165,415	\$	\$	34

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2024

Ending:

11/30/2025

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		\$ 6,150,914	\$ 165,415		\$ 165,415	\$	\$	1
2	Furnished and installed new duct insulation and	2025	27,493	458	15	458			2
3	install new insulation blankets over air diffusers								3
4	(Rose Hall wing)								4
5	Resident Room remodeling project -	2025	193,208	6,440	15	6,440			5
6	Facility is remodeling 54 resident rooms between 2025-2028								6
7	(8) rooms were started and completed in 2025. The								7
8	remodel consists of removing and replacing all								8
9	damaged drywall, painting all new and existing drywall,								9
10	replacing all existing carpet, installing vinyl planks in								10
11	the entry way and bathroom, installing new vanities,								11
12	sinks and showers (if deemed necessary) and installing								12
13	new cabinets								13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,371,615	\$ 172,313		\$ 172,313	\$	\$	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	\$1,769,552	\$53,434	\$53,434	\$		\$	71
72	Current Year Purchases	333,784						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,103,336	\$53,434	\$53,434	\$		\$	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	Transport	2024 Dodge Ram Promaster	2024	\$96,864	\$19,373	\$19,373	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$96,864	\$19,373	\$19,373	\$		\$	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)	\$8,571,815	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$245,120	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$245,120	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)	\$	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					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:None
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☒ XX NO Terms: *

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

15. Is Movable equipment rental included in building rental?☐ YES☒ XX NO
16. Rental Amount for movable equipment: \$13,821Description:Oxygen concentrators, copiers and printers
(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	None		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		5,503		5,503
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,503	\$	\$ 5,503
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,503			

- (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.

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	

- (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	\$		\$ 194,787	\$		\$ 194,787	1
2	Licensed Speech and Language Development Therapist		hrs			104,136			104,136	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			190,396	0		190,396	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				172,222		172,222	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					51,442			51,442	13
14	TOTAL			\$		\$ 540,761	\$ 172,222		\$ 712,983	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	\$5,423,401	\$	1
2	Cash-Patient Deposits	50,706		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	660,236		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	998		6
7	Other Prepaid Expenses	16,700		7
8	Accounts Receivable (owners or related parties)	50,187		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$6,202,228	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,283,102		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,197,200		16
17	Accumulated Depreciation (book methods)	(6,283,038)		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)	\$2,197,264	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$8,399,492	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$312,858	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,706		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	323,010		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,577		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	Bed Tax	13,342		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$712,493	\$	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)	\$712,493	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$7,686,999	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$8,399,492	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,003,893	1
2	Restatements (describe):		2
3	Depreciation calculated for cost report purposes but	68,840	3
4	never adjusted on the general ledger		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,072,733	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	674,266	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)	\$ 674,266	17
	B. Transfers (Itemize):		
18	Transfer to Menard County	(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)	\$ 7,686,999	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/01/2024

Ending: 11/30/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,207,318	1
2	Discounts and Allowances for all Levels	(1,245,070)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,962,248	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,152,814	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,152,814	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	147,283	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	244,703	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,750	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 395,736	23
	D. Non-Operating Revenue		
24	Contributions	7,663	24
25	Interest and Other Investment Income***	210,624	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 218,287	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Recovery of employee retention credits net of</u>	876,029	28
28a	<u>consultant fee</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 876,029	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,605,114	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,661,313	31
32	Health Care	4,150,594	32
33	General Administration	2,370,681	33
	B. Capital Expense		
34	Ownership	258,941	34
	C. Ancillary Expense		
35	Special Cost Centers	489,319	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,930,848	40
41	Income before Income Taxes (line 30 minus line 40)**	674,266	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 674,266	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,835,343.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,051,466.79	45
46	MMAI-Medicaid is the Primary Payer	1,327,658.21	46
47	MMAI-Medicare is the Primary Payer	5,551.00	47
48	Private Pay	1,172,439.85	48
49	Medicare Part A	320,236.00	49
50	Other-(specify) <u>Private Pay - Insurance</u>	296,967.15	50
51	Other-(specify) <u>Equipment rental</u>	4,991.00	51
52	Other-(specify) <u>Medicare Cost Report Settlement</u>	44,215.00	52
53	Other-(specify) <u>Medicare Bad Debts</u>	-96,620.00	53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,962,248	56

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	1,828	1,924	\$ 87,100	\$ 45.27	1
2	Assistant Director of Nursing	3,383	3,561	120,237	33.76	2
3	Registered Nurses	9,218	9,703	432,922	44.62	3
4	Licensed Practical Nurses	9,944	10,467	351,714	33.60	4
5	CNAs & Orderlies	53,917	56,755	1,486,499	26.19	5
6	CNA Trainees	366	366	5,503	15.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	311	311	11,590	37.27	8
9	Activity Director					9
10	Activity Assistants	5,099	5,367	94,072	17.53	10
11	Social Service Workers	1,997	2,102	58,532	27.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,412	19,381	374,237	19.31	15
16	Dishwashers					16
17	Maintenance Workers	6,239	6,568	143,250	21.81	17
18	Housekeepers	14,148	14,893	244,449	16.41	18
19	Laundry	5,527	5,818	99,856	17.16	19
20	Administrator	1,862	1,960	110,488	56.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,690	10,200	275,522	27.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	141,941	149,376	\$ 3,895,971 *	\$ 26.08	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		\$ 9,108	Ln 1 Col 3	35
36	Medical Director		24,000	Ln 9 Col 3	36
37	Medical Records Consultant		6,533	Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,846	Ln 10a Col 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		5,290	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 51,777		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,676	\$ 308,869	Ln10 Col 3	50
51	Licensed Practical Nurses	6,003	342,603	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides	10,802	366,198	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	21,481	\$ 1,017,670		53

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

** See instructions.

XX. GENERAL INFORMATION:

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

No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	9,222
	9,222 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	9,222
	9,222 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	18,444
	18,444 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	5,000	Line	10
----	-------	------	----
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$	159,600
----	---------

This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$	None	Has any meal income been offset against related costs?	Yes	Indicate the amount.	\$	10,689
----	------	--	-----	----------------------	----	--------
- (12) 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?

100%

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?

NA

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.

\$
- (13) Has an audit been performed by an independent certified public accounting firm?

Pending

Firm Name:
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

None Claimed

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

[illegible]

Sunny Acres Home of Menard County
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 172,222
Purchased Hospital Services	44,110
Purchased Laboratory Services	4,108
Purchased Radiology Services	3,224
Amount Reclassified to Line 39	\$ <u>223,664</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee	<u>159,600</u>

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant Cost

<u>Line Item</u>	
Pharmacy Consultant	\$ <u>6,846</u>

4. Schedule V - Line 21 to Line 10 - Reclass MDS and Medical Records Wages

<u>Line Item</u>	
MDS Coordinators/Care Planners - Line 21, Col 1	\$ 91,214
Medical Records Specialists - Line 21, Col 1	39,611
	\$ <u>130,825</u>
Nursing & Medical Records Line 10	\$ <u>130,825</u>