

		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: 0014076

Facility Name: Sunny Hill Nsg Home Will Co

Address: 421 Doris Avenue Joliet 60433
Number City Zip Code

County: Will

Telephone Number: (815) 727-8710 Fax # (815) 727-8637

HFS ID Number:

Date of Initial License for Current Owners: 1955

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY ☒ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☒ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler Telephone Number: (847) 940-3269
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 12/1/2024 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)
	(Title)
Paid Preparer	(Signed)
	(Date)
	(Print Name and Title) Andrew B. Cutler Managing Director, Healthcare
	(Firm Name & Address) FGMK, LLC 2801 Lakeside Drive, 3rd Floor, Bannockburn, IL 60015
	(Telephone) (847) 940-3269 Fax # (847) 964-5469

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 Hill Nsg Home Will Co # 0014076 Report Period Beginning: 12/1/2024 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 <u>N/A</u>					
	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	<u>157</u>	Skilled (SNF)	<u>157</u>	<u>57,305</u>	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	<u>157</u>	TOTALS	<u>157</u>	<u>57,305</u>	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	12,737	15,005	5,015	138	16,688	3,774	0	53,357	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	12,737	15,005	5,015	138	16,688	3,774		53,357	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 93.11%

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 1972

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 157

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS
ACCRUAL ☐ MODIFIED CASH* ☒ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 11/30/2025 Fiscal Year: 11/30/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number		Sunny Hill Nsg Home Will Co		STATE OF ILLINOIS		#	0014076	Report Period Beginning:		12/1/2024		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	1,192,443	29,398	11,759	1,233,600		1,233,600		1,233,600				1	
2	Food Purchase		908,360		908,360		908,360	(405)	907,955				2	
3	Housekeeping	733,081	102,562		835,643		835,643		835,643				3	
4	Laundry	90,606	26,406		117,012		117,012		117,012				4	
5	Heat and Other Utilities			322,627	322,627		322,627		322,627				5	
6	Maintenance		3,780	212,189	215,969		215,969	627,811	843,780				6	
7	Other (specify):*												7	
8	TOTAL General Services	2,016,130	1,070,506	546,575	3,633,211		3,633,211	627,406	4,260,617				8	
	B. Health Care and Programs													
9	Medical Director			14,400	14,400		14,400		14,400				9	
10	Nursing and Medical Records	8,784,148	533,682	2,193,036	11,510,866		11,510,866		11,510,866				10	
10a	Therapy	271,552			271,552		271,552		271,552				10a	
11	Activities	293,841	5,503		299,344		299,344		299,344				11	
12	Social Services	224,004			224,004		224,004		224,004				12	
13	CNA Training												13	
14	Program Transportation			6,038	6,038		6,038		6,038				14	
15	Other (specify):*												15	
16	TOTAL Health Care and Programs	9,573,545	539,185	2,213,474	12,326,204		12,326,204		12,326,204				16	
	C. General Administration													
17	Administrative	262,500			262,500		262,500		262,500				17	
18	Directors Fees												18	
19	Professional Services			68,079	68,079		68,079	1,094,968	1,163,047				19	
20	Dues, Fees, Subscriptions & Promotions			92,533	92,533		92,533	(4,609)	87,924				20	
21	Clerical & General Office Expenses	451,939	6,682	19,405	478,026		478,026	51,226	529,252				21	
22	Employee Benefits & Payroll Taxes			5,134,632	5,134,632		5,134,632	308,090	5,442,722				22	
23	Inservice Training & Education												23	
24	Travel and Seminar			2,967	2,967		2,967		2,967				24	
25	Other Admin. Staff Transportation												25	
26	Insurance-Prop.Liab.Malpractice							406,857	406,857				26	
27	Other (specify):*												27	
28	TOTAL General Administration	714,439	6,682	5,317,616	6,038,737		6,038,737	1,856,532	7,895,269				28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,304,114	1,616,373	8,077,665	21,998,152		21,998,152	2,483,938	24,482,090				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			760,879	760,879		760,879	40,340	801,219			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			95,566	95,566		95,566		95,566			35
36	Other (specify):*											36
37	TOTAL Ownership			856,445	856,445		856,445	40,340	896,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		215,746	594,975	810,721		810,721		810,721			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			313,341	313,341		313,341		313,341			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		215,746	908,316	1,124,062		1,124,062		1,124,062			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	12,304,114	1,832,119	9,842,426	23,978,659		23,978,659	2,524,278	26,502,937			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	(405)	02		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	40,340	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(5,352)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 34,583		\$	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)	2,489,695		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,489,695		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,524,278		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (4,609)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Finance Charge/Late Fees	(743)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(5,352)		49

Summary A

11/30/2025

[illegible]

Summary B

11/30/2025

[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
Will County	100%	N/A		Will County	Joliet	Governmental

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		\$ 627,811	\$ 627,811	1
2	V	19	Professional Services		Will County		1,094,968	1,094,968	2
3	V	21	Copy Fees		Will County		32,431	32,431	3
4	V	21	Telephone		Will County		19,538	19,538	4
5	V	22	Employee Benefits		Will County		308,090	308,090	5
6	V	26	Insurance		Will County		406,857	406,857	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 2,489,695	\$ * 2,489,695	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

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

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

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	See Ownership - 1	County Board	Administrative	0.00					\$		1
2		Member									2
3											3
4	No Services have been provided to the nursing home by board members.										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 Hill Nsg Home Will Co # 0014076 Report Period Beginning: 12/1/2024 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 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 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	6	Maintenance	% of Staff	137	1	\$ 627,811	\$ 627,811	137	\$ 627,811	1
2	19	Professioanl Services	% Hours/% Warrants	137	1	1,094,968	13,942	137	1,094,968	2
3	21	Copying Fees	% State	137	1	32,431		137	32,431	3
4	21	Telephone	% Hours/% Warrants	137	1	19,538		137	19,538	4
5	22	Employee Benefits	% Employees	137	1	308,090		137	308,090	5
6	26	Insurance	% Employees	137	1	406,857		137	406,857	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					\$ 2,489,695	\$ 641,753		\$ 2,489,695	25

Facility Name & ID Number Sunny Hill Nsg Home Will Co # 0014076 Report Period Beginning: 12/1/2024 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	N/A						\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10	N/A											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.	\$	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 2024 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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2025 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
Assessed Value from Real Estate Tax Bill:	2024	8		
Real Estate Tax Bill for Calendar Year:	2020	9		
	2021	10		
	2022	11		
	2023	12		
	2024	13		
Not Applicable - County does not pay real estate taxes			14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
			15	PLUS APPEAL COST FROM LINE 5 \$ 15
			16	LESS REFUND FROM LINE 6 \$ 16
			17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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 Hill Nsg Home Will Co COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Margaret McDowell, 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 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. N/A - County does not pay		\$	\$
2. real estate tax		\$	\$
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: 128,067 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
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. N/A
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 [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

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential 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	157		1972	1972	\$ 1,375,843	\$	40	\$	\$	\$ 1,375,843	4
5			1976	1976	1,198,083		40			1,198,083	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1970		727					727	9
10	Various		1972		51,575					51,575	10
11	Various		1973		37,155					37,155	11
12	Various		1974		38,466					38,466	12
13	Various		1975		155,856					155,856	13
14	Various		1976		57,254					57,254	14
15	Various		1976		26,031					26,031	15
16	Various		1972		183,817					183,817	16
17	Various		1972		522,443					522,443	17
18	Various		1976		262,534					262,534	18
19	Various		1976		508,942					508,942	19
20	Various		1975		83,460					83,460	20
21	Various		1981		107,858					107,858	21
22	Various		1987		819,813					819,813	22
23	Various		1985		85,920					85,920	23
24	Various		1989		3,040					3,040	24
25	Various		1992		162,867					162,867	25
26	Various		1992		3,284					3,284	26
27	Various		1993		105,136					105,136	27
28	Various		1994		108,852					108,852	28
29	Various		1995		66,260					66,260	29
30	Various		1996		362,815					362,815	30
31	Various		1997		4,990					4,990	31
32	Various		1992		7,040					7,040	32
33	Various		1996		2,212					2,212	33
34	Various		1998		11,734					11,734	34
35	Various		1999		72,294					72,294	35
36	Book Depreciation					760,879					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

XI. OWNERSHIP COSTS (continued)

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

1		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	Various	2000	\$ 17,847	\$		\$	\$	\$ 17,847	37
38	Various	2001	5,326					5,326	38
39	Various	2002	55,206					55,206	39
40	Various	2003	80,110					80,110	40
41	Various	2004	239,400					239,400	41
42	Various	2005	113,723					113,723	42
43	Various	2008	7,059					7,059	43
44	Various	2009	10,506,035			262,263	262,263	4,342,828	44
45	Various	2010	57,230			1,431	1,431	22,180	45
46	Various	2011	3,073,958			76,761	76,761	1,116,535	46
47	Various	2012	2,759,913			68,791	68,791	936,953	47
48	Various	2013	4,817,787			120,445	120,445	1,505,561	48
49	Various	2014	3,318,956			82,974	82,974	954,201	49
50	Various	2015	2,849,503			71,238	71,238	747,999	50
51	Various	2016	2,340,886			58,552	58,552	556,079	51
52	Various	2017	496,949			12,424	12,424	105,604	52
53	Nurse Call Light Control Unitand Keypads	2024	8,247		20	412	412	824	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 37,174,436	\$ 760,879		\$ 755,291	\$ 755,291	\$ 17,233,736	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$319,641	\$	\$5,588	\$5,588	5	\$137,598	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	2,534,469					2,534,469	73
74								74
75	TOTALS	\$2,854,110	\$	\$5,588	\$5,588		\$2,672,067	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	Resident Use	2018 Ford Starcraft Bus	2018	\$73,147	\$	\$	\$	5	\$73,147	76
77										77
78										78
79										79
80	TOTALS			\$73,147	\$	\$	\$		\$73,147	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$40,126,693	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$760,879	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$760,879	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$19,978,950	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: 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:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 95,566
- Description: See Attached
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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 of Will County
0014076
11/30/2025

XIV - Rental Costs
Line 14 Rental amount of Moveable Equipment

Description	Amount
Rental Equipment Executive Administrative	\$6,718.00
Rental Equipment Dietary	\$ 10,390
Rental Equipment Nursing	\$ 77,108
Rental Equipment Activities	\$ 1,350
	<u>\$ 95,566</u>

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	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)	\$			

- (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	39-3	hrs	\$		\$ 279,898	\$		\$ 279,898	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,703			25,703	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			263,772			263,772	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				132,760		132,760	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-2				25,602			25,602	12
13	Other (specify): See Attached	39-3					82,267		82,267	13
14	TOTAL			\$		\$ 594,975	\$ 215,027		\$ 810,002	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.

Line	Description	Amount
39-2	Therapy Supplies	\$ 5,571
39-2	Oxygen Supplies	\$ 12,250
39-2	Radiology Services	<u>\$ 64,446</u>
	Total	<u>\$ 82,267</u>
39-3	Lab Supplies	\$ 25,602
		\$ -
		<u>\$ 25,602</u>

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		13
14	Buildings, at Historical Cost	37,166,189		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,727,616		16
17	Accumulated Depreciation (book methods)	(19,978,950)		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)	\$ 19,939,855	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,939,855	\$	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			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)	\$	\$	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)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 19,939,855	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,939,855	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$20,700,734	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$20,700,734	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,312,332)	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)	\$(2,312,332)	17
	B. Transfers (Itemize):		
18	Interfund Transfers	1,551,453	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$1,551,453	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$19,939,855	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunny Hill Nsg Home Will Co

0014076

Report Period Beginning: 12/1/2024

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	\$ 21,187,555	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,187,555	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	384,700	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 384,700	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	405	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,817	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,119	19
20	Radiology and X-Ray	5,950	20
21	Other Medical Services	1,300	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 87,591	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	Sundries	6,481	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,481	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,666,327	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,633,211	31
32	Health Care	12,326,204	32
33	General Administration	6,038,737	33
	B. Capital Expense		
34	Ownership	856,445	34
	C. Ancillary Expense		
35	Special Cost Centers	810,721	35
36	Provider Participation Fee	313,341	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 23,978,659	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,312,332)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,312,332)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,827,398.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,564,771.00	45
46	MMAI-Medicaid is the Primary Payer	2,528,312.00	46
47	MMAI-Medicare is the Primary Payer	69,573.00	47
48	Private Pay	5,149,085.00	48
49	Medicare Part A	1,658,150.00	49
50	Other-(specify) Medicare B	390,266.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 21,187,555	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	1,856	2,080	\$ 119,208	\$ 57.31	1
2	Assistant Director of Nursing	5,664	6,240	291,482	46.71	2
3	Registered Nurses	45,286	52,000	2,724,702	52.40	3
4	Licensed Practical Nurses	37,707	43,680	1,764,057	40.39	4
5	CNAs & Orderlies	117,508	128,960	3,489,277	27.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,497	8,320	271,552	32.64	8
9	Activity Director	1,900	2,080	65,679	31.58	9
10	Activity Assistants	11,331	12,480	228,162	18.28	10
11	Social Service Workers	7,724	8,320	224,004	26.92	11
12	Dietician	1,890	2,080	97,265	46.76	12
13	Food Service Supervisor	3,545	4,160	134,431	32.32	13
14	Head Cook	1,805	2,080	76,119	36.60	14
15	Cook Helpers/Assistants	3,357	4,160	116,359	27.97	15
16	Dishwashers	29,082	31,200	768,269	24.62	16
17	Maintenance Workers					17
18	Housekeepers	29,550	33,280	733,081	22.03	18
19	Laundry	1,936	2,080	90,606	43.56	19
20	Administrator	2,020	2,080	122,367	58.83	20
21	Assistant Administrator	1,563	2,080	90,636	43.58	21
22	Other Administrative	1,915	2,080	49,497	23.80	22
23	Office Manager	1,856	2,080	75,812	36.45	23
24	Clerical	15,924	16,640	376,127	22.60	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	1,676	2,080	54,723	26.31	31
32	Other Health Care(specify)					32
33	Other(specify) Clerical RN/MDS	9,304	10,400	340,699	32.76	33
34	TOTAL (lines 1 - 33)	340,896	380,640	\$ 12,304,114 *	\$ 32.32	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	\$ 11,759	1-3	35
36	Medical Director	Monthly	14,400	9-3	36
37	Medical Records Consultant	Monthly	7,335	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,494		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	2,664	167,913	10-3	51
52	Certified Nurse Assistants/Aides	54,147	2,017,788	10-3	52
53	TOTAL (lines 50 - 52)	56,811	\$ 2,185,701		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberSunny Hill Nsg Home Will Co# 0014076Report Period Beginning:12/1/2024Ending:11/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret McDowell	Administrator	0	\$ 122,367
Jacqueline Palmer Hosey	Asst Administrator	0	90,636
June Smalec	Other Administrative	0	49,497
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 262,500

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
My ability	Data Processing	19,219
FGMK	Cost Reporting/Consulting	26,860
Duane Morris	Legal	1,728
The Fource Group	Digital Web	1,725
UIKG	Payroll	18,547
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 68,079

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$	
Unemployment Compensation Insurance		
FICA Taxes	900,959	
Employee Health Insurance	3,200,022	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*	978,802	
Other Employee Benefits	54,849	
Allocated Will County	308,090	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 5,442,722

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	900	
Health Care Worker Background Check (Indicate # of checks performed 100)	22,262	
Patient Background Checks 132	1,320	
Association Dues (total from pg 22, #4)	14,651	
Books Periodicals	661	
Dues & Subscriptions	52,739	
Less: Public Relations Expense	()	
PAC and Lobbying payments	(4,609)	
All non-allowable advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 87,924

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,967
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,967

* Attach copy of IMRF notifications

**See instructions.

Sunny Hill Nursing Home of Will County
0014076
11/30/2025

SEMINAR EXPENSE

DATE	DESCRIPTION	STAFF	DEPT	LOCATION	AMOUNT
11/15/2025	BMO INHAA Annual Convention	Margaret McDowell	ADMINISTRATION	Peoria	225.00
11/15/2025	BMO Food Handling Licenses and Training	Dietary	Dietary	Web	79.00
11/15/2025	BMO Infection Prevention Training	Clinical	ALL	Web	100.00
10/28/2025	Fire Extinguisher Training & Recharge-Inv-72879-VN-000131	ALL	ALL	Web	1,008.00
8/15/2025	BMO-CPR/AED Training & Instructing	Clinical	ALL	Web	37.50
8/15/2025	BMO-Virtual Conference	Administration	ALL	Web	180.00
6/15/2025	BMO-Food Safety for Handlers	Dietary	Dietary	Web	118.50
5/9/2025	05/10/25 Payroll GL DM Upload-New World JE 2500040	Clinical	Nursing	Web	539.00
2/15/2025	BMO-Seminar Registration	Clinical	Nursing	Web	80.00
2/15/2025	BMO-INHAA Virtual Conference	Clinical	Nursing	Web	180.00
1/15/2025	BMO-fy25 IHCA training	Clinical	Nursing	Web	420.00
	Total				<u>2,967.00</u>

Sunny Hill Nursing Home of Will County
0014076
11/30/2025

Legal

9/19/2025	Consulting Services-Inv-3287348-VN-000518	Daune Morris	Legal	1,728.00
Total				\$ 1,728.00

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (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
IL HEALTHCARE ASSOCIATION (IHCA)	10,042
	10,042

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.

IL HEALTHCARE ASSOCIATION (IHCA)	4,609
	4,609

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	14,651
	14,651

Total
- (5)

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

\$ 134,759

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.

\$ 313,341

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.

\$ Yes

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 405
- (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.

\$ N/A

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

LN 14

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?

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
- (13)

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

Firm Name: Baker Tilley

Yes
- (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.

Yes

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