

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning: 12-01-99 Ending: 11-30-00

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	15,229	22,473		37,702	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,229	22,473		37,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.45%

D. How many bed-hold days during this year were paid by Public Aid? 13 (Do not include bed-hold days in Section B.)

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

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 N/A NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: November 30

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

STATE OF ILLINOIS

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-99 Ending: 11-30-00

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	210,680	23,104	7,201	240,985		240,985		240,985		1
2	Food Purchase		171,905		171,905		171,905	(15,527)	156,378		2
3	Housekeeping	129,954	26,119		156,073		156,073		156,073		3
4	Laundry	43,558	12,288		55,846		55,846		55,846		4
5	Heat and Other Utilities			112,880	112,880		112,880		112,880		5
6	Maintenance	48,263	55,532		103,795		103,795		103,795		6
7	Other (specify):*										7
8	TOTAL General Services	432,455	288,948	120,081	841,484		841,484	(15,527)	825,957		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,312,694	93,260	49,809	1,455,763		1,455,763	(18,763)	1,437,000		10
10a	Therapy	47,422	1,000	1,862	50,284		50,284		50,284		10a
11	Activities	40,250	1,000	6,602	47,852		47,852		47,852		11
12	Social Services	73,720	2,000	2,549	78,269		78,269		78,269		12
13	Nurse Aide Training		566	5,000	5,566		5,566		5,566		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,474,086	97,826	71,822	1,643,734		1,643,734	(18,763)	1,624,971		16
	C. General Administration										
17	Administrative	111,596	16,897	7,357	135,850		135,850	(8,977)	126,873		17
18	Directors Fees										18
19	Professional Services			21,615	21,615		21,615	(1,368)	20,247		19
20	Dues, Fees, Subscriptions & Promotions			10,619	10,619		10,619	(1,400)	9,219		20
21	Clerical & General Office Expenses	40,045	4,633	4,891	49,569		49,569	(1,401)	48,168		21
22	Employee Benefits & Payroll Taxes			290,284	290,284		290,284		290,284		22
23	Inservice Training & Education			3,875	3,875		3,875		3,875		23
24	Travel and Seminar			524	524		524		524		24
25	Other Admin. Staff Transportation		741	2,245	2,986		2,986		2,986		25
26	Insurance-Prop.Liab.Malpractice			29,125	29,125		29,125		29,125		26
27	Other (specify):*										27
28	TOTAL General Administration	151,641	22,271	370,535	544,447		544,447	(13,146)	531,301		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,058,182	409,045	562,438	3,029,665		3,029,665	(47,436)	2,982,229		29

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

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

Facility Name & ID Number Sunny Acres Nursing Home

#0005009

Report Period Beginning:

12-01-99

Ending:

11-30-00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			158,330	158,330		158,330		158,330			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,694	63,694		63,694	(76,197)	(12,503)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			222,024	222,024		222,024	(76,197)	145,827			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	5,894		479	6,373		6,373	(17,995)	(11,622)			40
41	Coffee and Gift Shops		5,101		5,101		5,101	(8,186)	(3,085)			41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	5,894	5,101	58,514	69,509		69,509	(26,181)	43,328			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,064,076	414,146	842,976	3,321,198		3,321,198	(149,814)	3,171,384			45

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-99

Ending: 11-30-00

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,527)	2		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	(12,503)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(63,694)	32		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	(7,357)	17		19
20	Contributions	(1,401)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,368)	19		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	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,400)	20		28
29	Other-Attach Schedule	(46,564)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (149,814)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (149,814)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12-01-99

Ending: 11-30-00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
			Reference
1	medical supplies sold to residents	(18,763)	10 1
2	hair care revenues	(17,995)	40 2
3	vending machine sales	(8,186)	41 3
4	other reimbursements	(1,620)	17 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
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37			37
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39			39
40			40
41			41
42			42
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68			68
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70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(46,564)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-99

Ending:

11-30-00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,527)	0	0	0	0	0	0	0	0	0	0	(15,527)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(15,527)	0	0	0	0	0	0	0	0	0	0	(15,527)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(18,763)	0	0	0	0	0	0	0	0	0	0	(18,763)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(18,763)	0	0	0	0	0	0	0	0	0	0	(18,763)	16
	C. General Administration													
17	Administrative	(8,977)	0	0	0	0	0	0	0	0	0	0	(8,977)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,368)	0	0	0	0	0	0	0	0	0	0	(1,368)	19
20	Fees, Subscriptions & Promotions	(1,400)	0	0	0	0	0	0	0	0	0	0	(1,400)	20
21	Clerical & General Office Expenses	(1,401)	0	0	0	0	0	0	0	0	0	0	(1,401)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(13,146)	0	0	0	0	0	0	0	0	0	0	(13,146)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(47,436)	0	0	0	0	0	0	0	0	0	0	(47,436)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12-01-99

Ending:

11-30-00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(76,197)	0	0	0	0	0	0	0	0	0	0	(76,197) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(76,197)	0	0	0	0	0	0	0	0	0	0	(76,197) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	(17,995)	0	0	0	0	0	0	0	0	0	0	(17,995) 40
41	Coffee and Gift Shops	(8,186)	0	0	0	0	0	0	0	0	0	0	(8,186) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(26,181)	0	0	0	0	0	0	0	0	0	0	(26,181) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(149,814)	0	0	0	0	0	0	0	0	0	0	(149,814) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Menard County, Illinois	100%	None		Countryside Estates of Menard County	Petersburg, Illinois	independent living facility

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

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

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

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-99 Ending: 11-30-00

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	Not Applicable								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-99 Ending: 11-30-00

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	Not applicable				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-99 Ending: 11-30-00

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		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	Nursing Home Revenue Bonds		x	To partially finance the		04-28-98	\$ 1,550,000	\$ 1,295,000	04-28-08	0.0483	\$ 63,694	1								
2				construction of an independent								2								
3				living facility including the								3								
4				requisite equipment and								4								
5				fixtures								5								
	Working Capital																			
6	Menard County, Illinois	x		operating	none	11/30/98	54,520	54,520	demand	none	none	6								
7	Liability Insurance Fund	x		operating	none	11/30/99	76,342	76,342	demand	none	none	7								
8		x		operating	none	11/30/00	117,211	117,211	demand	none	none	8								
9	TOTAL Facility Related						\$ 1,798,073	\$ 1,543,073			\$ 63,694	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,798,073	\$ 1,543,073			\$ 63,694	15								

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number Sunny Acres Nursing Home# 0005009 Report Period Beginning: 12-01-99 Ending: 11-30-00

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 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 2000 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 used previously to calculate a payment rate. 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 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7
Real Estate Tax History:		
Real Estate Tax Bill for Calendar Year:	1995 _____ 8	
	1996 _____ 9	
	1997 _____ 10	
	1998 _____ 11	
	1999 _____ 12	
		FOR OFF USE ONLY
	13 FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14 PLUS APPEAL COST FROM LINE 5 \$	14
	15 LESS REFUND FROM LINE 6 \$	15
	16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Sunny Acres Nursing Home# 0005009 Report Period Beginning:12-01-99 Ending:11-30-00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,190 B. General Construction Type: Exterior brick Frame protected- noncombust Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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 assisted living facility adjacent to the nursing home. Countryside Estates of the County is accounted for and operates as a fund of Menard County.Menard County, through the Sunny Acres Nursing Home Fund, issued revenue bonds in April, 1998 to partially finance the construction of the independent living facility. That portion of the construction not financed with the proceeds of the revenue bond issue was financed with funds contributed by Sunny Acres Nursing Home Fund to Countryside Estates of the County.F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-99

Ending:

11-30-00

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	58	1966	1966	\$ 526,787	\$ 13,170	40	\$ 13,170		\$ 428,017	4
5	38	1977	1977	568,714	14,218	40	14,218		327,013	5
6		1984	1984	61,842	2,061	30	2,061		34,009	6
7	10	1993	1993	654,160	16,354	40	16,354		117,204	7
8		1995	1995	68,999	3,450	20	3,450		17,250	8
	Improvement Type**									
9	generator		1980	28,901		10			28,901	9
10	fire alarm system		1981	9,805		10			9,805	10
11	gazebo and floor coverings		1983	12,750	554	20-25	554		9,696	11
12	flooring, phone and paging systems, air conditioners		1984	30,885	532	10-25	532		25,855	12
13	sun room remodelling and wallpaper		1985	7,061	143	5-30	143		5,136	13
14	kitchen remodelling, wallpaper, parking lot, night lights, landscaping		1986	36,333	1,550	5-25	1,550		31,257	14
15	boiler repair, sprinkler system, office remodelling, wallpaper, air/cond		1987	17,193	450	5-25	450		15,135	15
16	roof, chimney, carpeting, sprinkler system		1988	147,826	40,893	5-25	40,893		104,016	16
17	compressor, canopy, carport		1989	6,472	293	15-30	293		3,404	17
18	asbestos removal, flooring, water heater, landscaping, canopy		1990	28,642	1,186	5-30	1,186		14,106	18
19	main air conditioning unit		1991	5,194	346	15	346		3,317	19
20	none		1992							20
21	new lagoon, tiling, hot water heater, aviary		1993	223,851	7,753	5-30	7,753		56,102	21
22	fill old lagoon, flooring, wallpaper and painting, sign for front		1994	49,671	122	5-25	122		38,922	22
23	major boiler repair and remodelling project		1995	10,685	796	5-10	796		8,400	23
24	special needs unit, resident walking gardens, vinyl soffets		1996	139,517	7,175	5-30	7,175		33,539	24
25	donor recognition wall, remodelling, draperies, shades, moldings		1997	20,798	3,860	5-10	3,860		13,580	25
26	major boiler repair, air conditioners, ceiling tile replacement		1998	21,699	2,007	10-15	2,007		4,720	26
27	two commercial water heaters, entrybath, rooftop air conditioning unit		1999	41,844	4,747	7-10	4,747		7,121	27
28	plumbing improvements, structural enhancements		2000	18,896	3,149	3	3,149		3,149	28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)			\$ 2,738,525	\$ 124,809		\$ 124,809	\$	\$ 1,339,654	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.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-99

Ending:

11-30-00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 256,498	\$ 23,042	\$ 23,042	\$	5-20	\$ 152,800	37
38	Current Year Purchases	83,901	8,390	8,390		5	8,390	38
39	Fully Depreciated Assets	241,540	2,089	2,089		5-20	241,540	39
40								40
41	TOTALS	\$ 581,939	\$ 33,521	\$ 33,521	\$		\$ 402,730	41

D. Vehicle Depreciation (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	
42	facility operations	1993 mercury sable	1994	\$ 12,925	\$	\$	\$		\$ 12,925	42
43	facility operations	1989 van	1989	20,735					20,735	43
44	facility operations	1989 van overhaul	1993	1,585					1,585	44
45										45
46	TOTALS			\$ 35,245	\$	\$	\$		\$ 35,245	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,355,709	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 158,330	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 158,330	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,777,629	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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

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.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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

9. Option to Buy: YES NO Terms: _____ *

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

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>90</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	1,150	\$	1,150
2	Books and Supplies		566		566
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		3,250		3,250
8	Nurse Aide Competency Tests		600		600
9	TOTALS	\$	5,566	\$	5,566
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,566		

C. CONTRACTUAL INCOME

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

\$ none

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-99

Ending:

11-30-00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11-30-00

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 239,612	\$ 116,776	1
2	Cash-Patient Deposits	3,700	3,700	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 30,000)	317,015	317,015	3
4	Supply Inventory (priced at cost)	19,218	22,735	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): due from other funds	11,673	11,673	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 591,218	\$ 471,899	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,351,011		12
13	Land			13
14	Buildings, at Historical Cost	2,738,525	5,048,034	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	624,127	700,790	16
17	Accumulated Depreciation (book methods)	(1,777,629)	(1,901,005)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		9,155	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,366)	20
21	Restricted Funds		312,575	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,936,034	\$ 4,167,183	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,527,252	\$ 4,639,082	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 70,730	\$ 173,700	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,700	7,900	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,096	93,096	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		4,660	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	bonds, current portion	135,000	135,000	36
37	due to other funds	20,140	20,140	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 322,666	\$ 434,496	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,160,000	1,160,000	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	due to other funds	400,000	400,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,560,000	\$ 1,560,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,882,666	\$ 1,994,496	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,644,586	\$ 2,644,586	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,527,252	\$ 4,639,082	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,769,425	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,769,425	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(124,839)	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)	\$ (124,839)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,644,586	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-99

Ending:

11-30-00

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,161,024	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,161,024	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	8,186	12
13	Barber and Beauty Care	17,995	13
14	Non-Patient Meals	15,527	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,620	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 43,328	23
D. Non-Operating Revenue			
24	Contributions	31,472	24
25	Interest and Other Investment Income***	(39,465)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (7,993)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,196,359	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	841,484	31
32	Health Care	1,643,734	32
33	General Administration	544,447	33
B. Capital Expense			
34	Ownership	222,024	34
C. Ancillary Expense			
35	Special Cost Centers	11,474	35
36	Provider Participation Fee	58,035	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,321,198	40
41	Income before Income Taxes (line 30 minus line 40)**	(124,839)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (124,839)	43

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

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

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-99

Ending:

11-30-00

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	2,149	49,958	22.82	1
2	Assistant Director of Nursing	1,189	19,617	16.50	2
3	Registered Nurses	8,228	139,181	16.45	3
4	Licensed Practical Nurses	17,024	252,980	14.15	4
5	Nurse Aides & Orderlies	91,152	850,958	8.63	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,999	20,471	10.12	9
10	Activity Assistants	1,652	19,779	10.37	10
11	Social Service Workers	6,151	73,720	10.66	11
12	Dietician				12
13	Food Service Supervisor	1,990	22,199	11.04	13
14	Head Cook				14
15	Cook Helpers/Assistants	7,952	83,639	9.61	15
16	Dishwashers	15,523	104,842	6.38	16
17	Maintenance Workers	4,123	48,263	10.64	17
18	Housekeepers	12,814	129,954	9.06	18
19	Laundry	5,804	43,558	6.66	19
20	Administrator	1,934	48,610	25.13	20
21	Assistant Administrator	1,718	29,630	17.25	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	3,245	40,045	10.96	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	4,163	47,422	11.34	30
31	Medical Records				31
32	Other Health Care(specify)	2,065	33,356	14.04	32
33	Other(specify)	514	5,894	10.09	33
34	TOTAL (lines 1 - 33)	191,389	2,064,076 *	10.01	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	173	7,201	1	35
36	Medical Director	24	6,000	9	36
37	Medical Records Consultant	9	270	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	10	39
40	Physical Therapy Consultant	14	1,862	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	2,549	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	280	19,082		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	24	986	10	50
51	Licensed Practical Nurses	1,553	43,526	10	51
52	Nurse Aides	253	3,827	10	52
53	TOTAL (lines 50 - 52)	1,830	48,339		53

Facility Name & ID Number Sunny Acres Nursing Home

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Marjorie Moritz	administrator	0	\$ 48,610	Workers' Compensation Insurance	\$ 66,921	IDPH License Fee	\$ 159	
Deanna Wagner	assistant administrator	0	29,630	Unemployment Compensation Insurance	211	Advertising: Employee Recruitment	10,112	
Diane Willing	quality assurance	0	33,356	FICA Taxes	151,981	Health Care Worker Background Check	348	
				Employee Health Insurance	29,087	(Indicate # of checks performed <u>79</u>)		
				Employee Meals	0			
				Illinois Municipal Retirement Fund (IMRF)*	42,084			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,596					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
employee recognition and awards			\$ 7,357			Non-allowable advertising	()	
						Yellow page advertising	(1,400)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 7,357	TOTAL (agree to Schedule V, line 22, col.8)	\$ 290,284	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,219	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Michael J. Feriozzi, CPA	audit and consulting		\$ 19,000				Out-of-State Travel	\$
Van Ostrand & Elvidge Kelly	legal		1,368					
Little and Co	payroll processing		1,247				In-State Travel	
							Seminar Expense	524
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 21,615	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 524

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sunny Acres Nursing Home# 0005009Report Period Beginning: 12-01-99Ending: 11-30-00**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. life services of illinois \$4,065
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 4 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,300 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES no NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 58,035
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ none Has any meal income been offset against related costs? yes Indicate the amount. \$ 15,527
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ none
- c. What percent of all travel expense relates to transportation of nurses and patients? 50%
- d. Have vehicle usage logs been maintained? no
- 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? yes
- 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. \$ none
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Michael J. Feriozzi, CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. will be provided at a later date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

Sunny Acres Nursing Home
#000509

Schedule XV, Balance Sheet

Column 2 explanation

The consolidated presentation presents Sunny Acres Nursing Home and its wholly owned independent living facility, Countryside Estate

Schedule XVI, Income Statement

line 25 interest and investment income

interest income	\$ 12,503
net income, independent living facility, equity method of accounting	<u>(51,968)</u>
	<u><u>\$ (39,465)</u></u>

Schedule XVII, Staffing and Salary costs

line 32 quality assurance

line 33 beautician