

		FOR BHF USE					

LL1

**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0005009

**Facility Name:** Sunny Acres Nursing Home

**Address:** Rural Route 3 Petersburg 62675  
 Number City Zip Code

**County:** Menard

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

**HFS ID Number:** 376005977001

**Date of Initial License for Current Owners:** 1966

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Mr. Lester E. Robertson Jr. **Telephone Number:** 217-632-2334

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12-01-05 to 11-30-06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Mr. Lester E. Robertson Jr.</u>	
	(Title) <u>Administrator</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Mr. Michael J. Feriozzi</u> <u>Certified Public Accountant</u>	
	(Firm Name & Address) <u>Michael J. Feriozzi, C.P.A.</u> <u>1316 S. Glenwood Springfield, Illinois 62704</u>	
	(Telephone) <u>217-522-8689</u> Fax # <u>217-632-7092</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Sunny Acres Nursing Home

# 0005009 Report Period Beginning: 12-01-05 Ending: 11-30-06

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 106

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

meals for menard county inmates and head start

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

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

Date started 12-01-66

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 106 and days of care provided 3,109

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,109	3,109	8
9	SNF/PED					9
10	ICF	19,952	10,114		30,066	10
11	ICF/DD		0			11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,952	10,114	3,109	33,175	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.75%

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-05 Ending: 11-30-06

**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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	202,190	16,576	3,617	222,383		222,383		222,383			1
2	Food Purchase		219,751		219,751	(41,610)	178,141	(30,987)	147,154			2
3	Housekeeping	132,166	28,490		160,656		160,656		160,656			3
4	Laundry	34,079	10,149		44,228		44,228		44,228			4
5	Heat and Other Utilities			152,125	152,125		152,125		152,125			5
6	Maintenance	55,961	60,715	6,761	123,437		123,437		123,437			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>424,396</b>	<b>335,681</b>	<b>162,503</b>	<b>922,580</b>	<b>(41,610)</b>	<b>880,970</b>	<b>(30,987)</b>	<b>849,983</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,371,096	112,607	197,260	1,680,963		1,680,963	(34,715)	1,646,248			10
10a	Therapy	24,898	85,500	260,583	370,981	(346,083)	24,898		24,898			10a
11	Activities	51,276	8,761		60,037		60,037		60,037			11
12	Social Services	77,347	3,000	3,152	83,499		83,499		83,499			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,524,617</b>	<b>209,868</b>	<b>472,995</b>	<b>2,207,480</b>	<b>(346,083)</b>	<b>1,861,397</b>	<b>(34,715)</b>	<b>1,826,682</b>			16
	<b>C. General Administration</b>											
17	Administrative	68,998		64,940	133,938		133,938	(56,198)	77,740			17
18	Directors Fees											18
19	Professional Services			71,471	71,471		71,471		71,471			19
20	Dues, Fees, Subscriptions & Promotions			41,848	41,848		41,848	(6,374)	35,474			20
21	Clerical & General Office Expenses	51,792	10,918	19,405	82,115		82,115		82,115			21
22	Employee Benefits & Payroll Taxes			356,343	356,343	41,610	397,953		397,953			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,044	3,044		3,044		3,044			24
25	Other Admin. Staff Transportation			4,016	4,016		4,016		4,016			25
26	Insurance-Prop.Liab.Malpractice			49,969	49,969		49,969		49,969			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>120,790</b>	<b>10,918</b>	<b>611,036</b>	<b>742,744</b>	<b>41,610</b>	<b>784,354</b>	<b>(62,572)</b>	<b>721,782</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,069,803</b>	<b>556,467</b>	<b>1,246,534</b>	<b>3,872,804</b>	<b>(346,083)</b>	<b>3,526,721</b>	<b>(128,274)</b>	<b>3,398,447</b>			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: 12-01-05 Ending: 11-30-06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			154,652	154,652		154,652		154,652			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,665	23,665		23,665	(23,665)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			178,317	178,317		178,317	(23,665)	154,652			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					346,083	346,083		346,083			39
40	Barber and Beauty Shops	6,785	212		6,997		6,997	(6,997)				40
41	Coffee and Gift Shops		3,768		3,768		3,768	(3,768)				41
42	Provider Participation Fee			58,034	58,034		58,034		58,034			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	6,785	3,980	58,034	68,799	346,083	414,882	(10,765)	404,117			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,076,588	560,447	1,482,885	4,119,920		4,119,920	(162,704)	3,957,216			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: 12-01-05

Ending: 11-30-06

**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	(30,987)	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				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	(23,429)	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	(4,550)	17		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	(51,648)	17		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	(6,374)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (116,988)		\$	30

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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (116,988)		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	Special services see page 16	x		242,745	line 10a	39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology	x		23,724	line 10a	42
43	Prescription Drugs	x		79,614	line 10a	43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 346,083		47

BHF USE ONLY						
48		49		50		52

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12-01-05

Ending: 11-30-06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	medical supplies sold to residents	\$ (34,715)	10	1
2				2
3	hair care revenues	(6,997)	40	3
4				4
5	coffee and gift shop	(3,768)	41	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	<b>Total</b>	(45,480)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning:

12-01-05

Ending:

11-30-06

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(30,987)	0	0	0	0	0	0	0	0	0	0	(30,987)	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	<b>TOTAL General Services</b>	<b>(30,987)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(30,987)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(34,715)	0	0	0	0	0	0	0	0	0	0	(34,715)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(34,715)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(34,715)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(56,198)	0	0	0	0	0	0	0	0	0	0	(56,198)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,374)	0	0	0	0	0	0	0	0	0	0	(6,374)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Administration</b>	<b>(62,572)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(62,572)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(128,274)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(128,274)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning:

12-01-05 Ending:

11-30-06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(23,429)	0	0	0	0	0	0	0	0	0	0	(23,429)	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	<b>TOTAL Ownership</b>	<b>(23,429)</b>	<b>0</b>	<b>(23,429)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(6,997)	0	0	0	0	0	0	0	0	0	0	(6,997)	40
41	Coffee and Gift Shops	(3,768)	0	0	0	0	0	0	0	0	0	0	(3,768)	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	<b>TOTAL Special Cost Centers</b>	<b>(10,765)</b>	<b>0</b>	<b>(10,765)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(162,468)</b>	<b>0</b>	<b>(162,468)</b>	<b>45</b>									

Facility Name & ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning:

12-01-05

Ending:

11-30-06

**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
<u>Menard County, Illinois</u>				<u>Countryside Esates of the County</u>	<u>Petersburg, Illinois</u>	<u>independent living facility</u>

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	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	<b>Total</b>		\$			\$	\$ *	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: 12-01-05 Ending: 11-30-06

## 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:

12-01-05

Ending: 11-30-06

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					\$	\$		\$	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	<b>A. Directly Facility Related</b>												
	<b>Long-Term</b>												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	<b>Working Capital</b>												
6	<b>Loan from Menard County</b>											6	
7	<b>General Fund</b>	x		<b>finance accounts receivable</b>	<b>\$6,120.00</b>	<b>11-30-05</b>		<b>73,434</b>		<b>11-30-06</b>	<b>0.0200</b>	<b>236</b>	7
8												8	
9	<b>TOTAL Facility Related</b>				<b>\$6,120.00</b>		<b>\$</b>	<b>73,434</b>	<b>\$</b>			<b>\$ 236</b>	9
	<b>B. Non-Facility Related*</b>												
10	<b>nursing home revenue</b>		x	<b>to partially finance the</b>	<b>\$16,610.00</b>	<b>04-28-98</b>		<b>1,550,000</b>	<b>375,000</b>	<b>04-28-08</b>	<b>0.0483</b>	<b>23,429</b>	10
11	<b>bonds</b>			<b>construction costs of an</b>								11	
12				<b>independent living facility</b>								12	
13												13	
14	<b>TOTAL Non-Facility Related</b>				<b>\$16,610.00</b>		<b>\$</b>	<b>1,550,000</b>	<b>\$ 375,000</b>			<b>\$ 23,429</b>	14
15	<b>TOTALS (line 9+line14)</b>						<b>\$</b>	<b>1,623,434</b>	<b>\$ 375,000</b>			<b>\$ 23,665</b>	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , 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 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	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:				
2001	<u>none</u>	8		
2002	<u>none</u>	9		
2003	<u>none</u>	10		
2004	<u>none</u>	11		
2005	<u>none</u>	12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Sunny Acres Nursing Home COUNTY Menard

FACILITY IDPH LICENSE NUMBER 0005009

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning:

12-01-05

Ending:

11-30-06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 41,190 B. General Construction Type: Exterior brick Frame protected noncombust Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>county owned land that the nursing home</u>		<u>1966</u>	<u>\$ 25,000</u>	1
2	<u>and independent living facility are situated on</u>				2
3	<b>TOTALS</b>			<b>\$ 25,000</b>	3

Facility Name &amp; ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning:

12-01-05

Ending:

11-30-06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1966	1966	\$ 526,787	\$ 13,170	40	\$ 13,170		\$ 507,036	4
5	38		1977	1977	568,714	14,218	40	14,218		412,321	5
6			1984	1984	61,842	2,061	30	2,061		46,377	6
7	10		1993	1993	654,160	16,354	40	16,354		215,328	7
8			1995	1995	68,999	3,450	20	3,450		37,950	8
	<b>Improvement Type**</b>										
9		generator		1980	28,901		10			28,901	9
10		fire alarm system		1981	9,805		10			9,805	10
11		none		1982							11
12		gazebo and floor coverings		1983	12,750	836	20-23	836		12,750	12
13		flooring, phone, and paging systems, air conditioner		1984	30,885	502	10-25	502		29,624	13
14		sun room, remodelling, wallpaper		1985	7,061	673	5-30	673		6,527	14
15		kitchen remodelling, wallpaper, parking lot, nightlight, etc		1986	36,333	299	5-25	299		35,709	15
16		boiler repair, sprinkler system, office remodelling, air conditioner		1987	17,193	161	5-25	161		16,540	16
17		roof, chimney, carpeting, sprinkler system,		1988	147,826	589	5-25	589		147,523	17
18		compressor, canopy, carport		1989	6,472	1,846	15	1,846		6,472	18
19		asbestos removal, flooring, water heater, landscaping, canopy		1990	28,642	9,580	5-15	9,580		28,642	19
20		main air conditioning unit		1991	5,194	146	15	146		5,194	20
21		none		1992							21
22		new lagoon, tiling, hot water heater, aviary		1993	223,851	4,246	13	4,246		223,851	22
23		fill old lagoon, flooring, wallpaper, and sign		1994	49,671	5,445	12	5,445		49,671	23
24		major boiler repair, air conditioners, ceiling tile replacement		1995	10,685	162	5-10	162		10,685	24
25		special needs unit, resident walking gardens, vinyl soffets		1996	139,517	5,018	5-30	5,018		69,483	25
26		donor recognitions wall, remodelling, draperies, shades		1997	20,798	385	5-10	385		20,798	26
27		major boiler repair, air conditioners, ceiling tile replacement		1998	21,699	6,941	5	6,941		21,699	27
28		two commercial water heaters, entrybath, rooftop air conditioner		1999	41,844	3,809	7-10	3,809		34,663	28
29		plumbing improvements, structural improvements		2000	18,896		5			18,896	29
30		plumbing, electrical, boiler rehabilitation		2001	22,162	2,217	5	2,217		22,162	30
31		structural improvements, sewer line and walls		2002	77,846	5,618	10-15	5,618		23,408	31
32		seal parking lot, fence improvements		2003	16,153	2,164	5-10	2,164		7,111	32
33		flooring, alarm systems, office remodelling etc		2004	67,361	5,532	10-20	5,532		13,902	33
34		kitchen tile and ceiling, carpeting, drapes, circuit improvements		2005	17,158	1,715	10	1,715		2,573	34
35		entrance improvements, wiring cable system, front doors		2006	45,926	2,159	10-20	2,159		2,159	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning:

12-01-05

Ending:

11-30-06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								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)	\$ 2,985,131	\$ 109,296		\$ 109,296	\$	\$ 2,067,760	70

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-05 Ending: 11-30-06

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	
71	Purchased in Prior Years	\$ 270,153	\$ 28,236	\$ 28,236	\$	5-20	\$ 152,802	71
72	Current Year Purchases	73,936	1,844	1,844		3-10	1,844	72
73	Fully Depreciated Assets	570,730	8,582	8,582		5-20	570,730	73
74								74
75	TOTALS	\$ 914,819	\$ 38,662	\$ 38,662	\$		\$ 725,376	75

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	
76	facility operations	1989 van	1989	\$ 22,320	\$	\$	\$	3	\$ 22,320	76
77	facility operations	2006 Ford Supreme van	2006	44,625	6,694	6,694		5	6,694	77
78										78
79										79
80	TOTALS			\$ 66,945	\$ 6,694	\$ 6,694	\$		\$ 29,014	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)		\$ 3,991,895	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 154,652	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 154,652	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,822,150	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: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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	<b>TOTAL</b>		\$ _____	\$ _____	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 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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	\$			

**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)	
<b>TOTAL TRAINED</b>	<b>none</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a (2 and 3)	hrs	\$		\$ 102,689	\$ 2,590		\$ 105,279	1
2	Licensed Speech and Language Development Therapist	10a (2 and 3)	hrs			22,292	589		22,881	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a (2 and 3)	hrs			111,878	2,707		114,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10 (2)	# of prescrpts				79,614		79,614	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	10a (3)				23,724			23,724	13
14	<b>TOTAL</b>			\$		\$ 260,583	\$ 85,500		\$ 346,083	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.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-05 Ending: 11-30-06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11-30-06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,100	\$ 25,100	1
2	Cash-Patient Deposits	187,116	197,131	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>123,807</u> )	655,048	632,696	3
4	Supply Inventory (priced at <u>fifo</u> )	18,000	21,517	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 861,264	\$ 876,444	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,934,000		12
13	Land			13
14	Buildings, at Historical Cost	2,985,134	5,333,379	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	981,761	1,072,524	16
17	Accumulated Depreciation (book methods)	(2,822,150)	(3,559,018)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	9,155	9,155	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,862)	(7,862)	20
21	Restricted Funds	1,158,419	1,387,688	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,238,457	\$ 4,235,866	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,099,721	\$ 5,112,310	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 131,272	\$ 133,846	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	187,116	197,131	28
29	Short-Term Notes Payable	185,000	185,000	29
30	Accrued Salaries Payable	168,601	168,601	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,287	36,287	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,578	1,578	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>deferred revenue</u>	47,853	47,853	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 757,707	\$ 770,296	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	190,000	190,000	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 190,000	\$ 190,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 947,707	\$ 960,296	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,152,014	\$ 4,152,014	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,099,721	\$ 5,112,310	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,687,210	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,687,210	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	524,804	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)	\$ 524,804	17
<b>B. Transfers (Itemize):</b>			
18	return of contributed capital to the general fund	(60,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (60,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,152,014	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Sunny Acres Nursing Home# 0005009Report Period Beginning: 12-01-05Ending: 11-30-06**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,457,286	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,457,286	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,651	12
13	Barber and Beauty Care	9,131	13
14	Non-Patient Meals	30,987	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	34,715	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 80,484	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	17,958	24
25	Interest and Other Investment Income***	88,996	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 106,954	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,644,724	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	922,580	31
32	Health Care	2,207,480	32
33	General Administration	742,744	33
<b>B. Capital Expense</b>			
34	Ownership	178,317	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	10,765	35
36	Provider Participation Fee	58,034	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,119,920	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	524,804	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 524,804	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:

12-01-05

Ending:

11-30-06

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	1,944	2,150	\$ 50,777	\$ 23.62	1
2	Assistant Director of Nursing	2,030	2,179	42,429	19.47	2
3	Registered Nurses	7,946	8,637	163,611	18.94	3
4	Licensed Practical Nurses	18,838	21,829	347,956	15.94	4
5	CNAs & Orderlies	59,490	69,585	744,255	10.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,630	1,798	24,898	13.85	8
9	Activity Director	1,868	1,985	21,513	10.84	9
10	Activity Assistants	3,131	3,612	29,763	8.24	10
11	Social Service Workers	5,565	6,299	77,347	12.28	11
12	Dietician					12
13	Food Service Supervisor	2,059	2,098	26,606	12.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,582	6,014	59,961	9.97	15
16	Dishwashers	15,274	16,114	115,623	7.18	16
17	Maintenance Workers	4,920	5,410	55,961	10.34	17
18	Housekeepers	13,460	15,087	132,166	8.76	18
19	Laundry	4,340	4,730	34,079	7.20	19
20	Administrator	1,837	1,998	68,998	34.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,541	4,127	51,792	12.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,394	1,624	22,068	13.59	32
33	Other(specify)	549	654	6,785	10.37	33
34	TOTAL (lines 1 - 33)	155,398	175,930	\$ 2,076,588 *	\$ 11.80	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	72	\$ 3,617	line 1 (3)	35
36	Medical Director	120	12,000	line 9 (3)	36
37	Medical Records Consultant	54	1,620	line 10 (3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,200	line 10 (3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	3,152	line 12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	318	\$ 21,589		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	2,307	79,154	line 10 c	51
52	Certified Nurse Assistants/Aides	5,984	115,286	line 10 c	52
53	TOTAL (lines 50 - 52)	8,291	\$ 194,440		53

Facility Name & ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning: 12-01-05

Ending: 11-30-06

**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	
Lester E. Robertson Jr.	administrator	none	\$ 68,998	Workers' Compensation Insurance	\$ 69,179	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	1,708	Advertising: Employee Recruitment	3,927	
				FICA Taxes	148,351	Health Care Worker Background Check	1,653	
				Employee Health Insurance	89,629	(Indicate # of checks performed 102 )		
				Employee Meals	41,610	Patient Background Checks (157)	2,512	
				Illinois Municipal Retirement Fund (IMRF)*	47,476	Other advertising	22,801	
						Dues and memberships	7,265	
						Other fees	2,695	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,998					
B. Administrative - Other								
Description			Amount					
			\$			Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	(6,374)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 397,953	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,474	
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	audit and accounting		\$ 21,000			\$	Out-of-State Travel	\$ 0
Revere Healthcare Ltd.	financial consulting		36,220					
Duane Morris LLP	legal		11,671				In-State Travel	4,016
Administrative Services	cafeteria plan administration		2,580					
							Seminar Expense	2,764
							Entertainment Expense	( 0 )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 71,471	TOTAL		\$ none	(agree to Sch. V, line 24, col. 8)	\$ 6,780

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Sunny Acres Nursing Home

# 0005009

Report Period Beginning: 12-01-05

Ending: 11-30-06

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. IHCA \$6,745
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,448 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 x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,034  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 41,610 Has any meal income been offset against related costs? yes Indicate the amount. \$ 30,987
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? 98%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Michael J. Feriozzi, C.P.A. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**Section V, Part A, Line 2, column 5**

The amount, 41,610 is the computed cost of employee provided meals during the year ended November 30, 2006.

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

The amount, 346,083, is the total of ancillary costs from page 16

**Section XIV Special Services Line 13 Other**

Cost of radiology services	14,415
Cost of laboratory services	<u>9,309</u>
	<u>23,724</u>

**Schedule XV, balance sheet, explanation of consolidation column**

The consolidation presents Sunny Acres Nursing Home and its investment in Countryside Estates of the County and the County's equity in the Sunny Acres Intergovernmental Transfer Fund. The financial reporting entity is discussed in the notes to the audited financial statements for Sunny Acres Nursing Home for the year ended November 30, 2006.

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

interest income	39,008	23,665 of this income was used to offset interest expense see page 4 section 5 line 32
nursing home's increase in its investment in its wholly owned independent living facility reported using the equity method of accounting	<u>49,988</u>	
	<u>88,996</u>	