

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

<p>I. IDPH License ID Number: <u>0014076</u></p> <p>Facility Name: <u>Sunny Hill Nursing Home of Will County</u></p> <p>Address: <u>421 Doris Avenue</u> <u>Joliet</u> <u>60433</u> Number City Zip Code</p> <p>County: <u>Will</u></p> <p>Telephone Number: <u>(815) 727-8710</u> Fax # <u>(815) 727-8637</u></p> <p>HFS ID Number: <u>366006672001</u></p> <p>Date of Initial License for Current Owners: <u>1955</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 789-7700</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<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	IRS Exemption Code _____	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/06</u> to <u>11/30/07</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 S. Old State Capitol Plaza, Ste. 200, Springfield Illinois 627</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 S. Old State Capitol Plaza, Ste. 200, Springfield Illinois 627</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076 Report Period Beginning: 12/01/06 Ending: 11/30/07

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 9/1/2007

	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	100	Skilled (SNF)	300	54,700	1
2		Skilled Pediatric (SNF/PED)			2
3	200	Intermediate (ICF)		54,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	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	4,613	484	6,798	11,895	8
9	SNF/PED					9
10	ICF	42,429	12,670	6,689	61,788	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,042	13,154	13,487	73,683	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.29%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 50 and days of care provided 6,697

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: No Tax Year Fiscal Year: 11/30/2007

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

Facility Name & ID Number Sunny Hill Nursing Home of Will County # 0014076 Report Period Beginning: 12/01/06 Ending: 11/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	755,237		16,780	772,017		772,017		772,017		1
2	Food Purchase		518,931		518,931		518,931	(4,431)	514,500		2
3	Housekeeping	924,087	95,644		1,019,731		1,019,731		1,019,731		3
4	Laundry	245,644		25,910	271,554		271,554		271,554		4
5	Heat and Other Utilities			328,499	328,499		328,499		328,499		5
6	Maintenance		3,290	106,494	109,784		109,784	563,125	672,909		6
7	Other (specify):*										7
8	TOTAL General Services	1,924,968	617,865	477,683	3,020,516		3,020,516	558,694	3,579,210		8
	B. Health Care and Programs										
9	Medical Director			3,500	3,500		3,500		3,500		9
10	Nursing and Medical Records	6,542,421	455,965	265,471	7,263,857		7,263,857	(14,852)	7,249,005		10
10a	Therapy		11,436	533,100	544,536		544,536		544,536		10a
11	Activities	264,738		600	265,338		265,338		265,338		11
12	Social Services	255,309			255,309		255,309		255,309		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,062,468	467,401	802,671	8,332,540		8,332,540	(14,852)	8,317,688		16
	C. General Administration										
17	Administrative	196,931			196,931		196,931		196,931		17
18	Directors Fees										18
19	Professional Services			42,444	42,444		42,444	967,670	1,010,114		19
20	Dues, Fees, Subscriptions & Promotions			24,936	24,936		24,936	(4,797)	20,139		20
21	Clerical & General Office Expenses	389,765	14,089	40,258	444,112		444,112	39,369	483,481		21
22	Employee Benefits & Payroll Taxes			135,623	135,623		135,623	4,382,510	4,518,133		22
23	Inservice Training & Education			1,639	1,639		1,639		1,639		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			341	341		341		341		25
26	Insurance-Prop.Liab.Malpractice							270,895	270,895		26
27	Other (specify):*										27
28	TOTAL General Administration	586,696	14,089	245,241	846,026		846,026	5,655,647	6,501,673		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,574,132	1,099,355	1,525,595	12,199,082		12,199,082	6,199,489	18,398,571		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			224,479	224,479		224,479		224,479			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93	93		93	(93)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			2,748	2,748		2,748		2,748			34
35	Rent-Equipment & Vehicles			70,839	70,839		70,839		70,839			35
36	Other (specify):*											36
37	TOTAL Ownership			298,159	298,159		298,159	(93)	298,066			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,321		105,321		105,321		105,321			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):* Non-allowable Cos			8,523	8,523		8,523	(8,523)				43
44	TOTAL Special Cost Centers		105,321	172,773	278,094		278,094	(8,523)	269,571			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,574,132	1,204,676	1,996,527	12,775,335		12,775,335	6,190,873	18,966,208			45

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

**See schedule of adjustments attached at end of cost report.

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,431)	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	(93)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,008)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(30,089)	21		28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(27,164)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,785)		\$	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)	6,253,658		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,253,658		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 6,190,873		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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Nursing Home of Will County

ID# 0014076

Report Period Beginning: 12/01/06

Ending: 11/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Chamber of Commerce Dues	\$ (230)	20	1
2	Lab Services	(8,523)	43	2
3	Disallow non-allowable radiology services	(14,852)	10A	3
4	Disallow IHCA PAC dues	(3,559)	20	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
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,164)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Hill Nursing Home of Will County# 0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,431)	0	0	0	0	0	0	0	0	0	0	(4,431)	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	563,125	0	0	0	0	0	0	0	0	0	563,125	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,431)	563,125	0	558,694	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	(14,852)	0	0	0	0	0	0	0	0	0	0	(14,852)	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	TOTAL Health Care and Programs	(14,852)	0	0	0	0	0	0	0	0	0	0	(14,852)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	967,670	0	0	0	0	0	0	0	0	0	967,670	19
20	Fees, Subscriptions & Promotions	(4,797)	0	0	0	0	0	0	0	0	0	0	(4,797)	20
21	Clerical & General Office Expenses	(30,089)	4,405,952	0	0	0	0	0	0	0	0	0	4,375,863	21
22	Employee Benefits & Payroll Taxes	0	46,016	0	0	0	0	0	0	0	0	0	46,016	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	270,895	0	0	0	0	0	0	0	0	0	270,895	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(34,886)	5,690,533	0	5,655,647	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,169)	6,253,658	0	6,199,489	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Hill Nursing Home of Will County# 0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

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	(93)	0	0	0	0	0	0	0	0	0	0	(93)	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	(93)	0	0	0	0	0	0	0	0	0	0	(93)	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	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,523)	0	0	0	0	0	0	0	0	0	0	(8,523)	43
44	TOTAL Special Cost Centers	(8,523)	0	0	0	0	0	0	0	0	0	0	(8,523)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(62,785)	6,253,658	0	0	0	0	0	0	0	0	0	6,190,873	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
<u>Will County</u>	<u>100%</u>	<u>N/A</u>		<u>Will County</u>	<u>Joliet</u>	<u>Government</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	<u>6 Maintenance</u>	\$	<u>Will County</u>	<u>100.00%</u>	\$ <u>563,125</u>	\$	<u>563,125</u> 1
2	V	<u>19 Professional Services</u>		<u>Will County</u>	<u>100.00%</u>	<u>967,670</u>		<u>967,670</u> 2
3	V	<u>21 Film Processing</u>		<u>Will County</u>	<u>100.00%</u>	<u>23,442</u>		<u>23,442</u> 3
4	V	<u>21 Telephone</u>		<u>Will County</u>	<u>100.00%</u>	<u>4,382,510</u>		<u>4,382,510</u> 4
5	V	<u>22 Employee Benefits</u>		<u>Will County</u>	<u>100.00%</u>	<u>46,016</u>		<u>46,016</u> 5
6	V	<u>26 Insurance</u>		<u>Will County</u>	<u>100.00%</u>	<u>270,895</u>		<u>270,895</u> 6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ <u>6,253,658</u>	\$ *	<u>6,253,658</u> 14

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

Facility Name & ID Number Sunny Hill Nursing Home of Will County # 0014076 Report Period Beginning: 12/01/06 Ending: 11/30/07

VII. RELATED PARTIES (continued)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending: 11/30/07

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

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	6	Maintenance	Direct cost	N/A	1	\$ 563,125	\$ 1	\$ 563,125	1
2	19	Professional services	Number of warrants	N/A	1	967,670	1	967,670	2
3	21	Film processing	Estimated time	N/A	1	23,442	1	23,442	3
4	22	Employee benefits	Direct cost	N/A	1	4,382,510	1	4,382,510	4
5	21	Telephone	Direct cost	N/A	1	46,016	1	46,016	5
6	26	Insurance	Direct cost	N/A	1	270,895	1	270,895	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					\$ 6,253,658	\$	\$ 6,253,658	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

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		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6												6						
7	Various		X	Finance Charges								93						
8												8						
9	TOTAL Facility Related						\$	\$			\$	93						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	(93)						
15	TOTALS (line 9+line14)						\$	\$			\$	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 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.)	2006	\$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	_____	8	
	2003	_____	9	
	2004	_____	10	
	2005	_____	11	
	2006	_____	12	
Not applicable - county does not pay real estate taxes.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Hill Nursing Home of Will County COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Karen Sobero, Administrator

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. <u>N/A - county does not pay real estate taxes</u>		\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 128,067 B. General Construction Type: Exterior Brick Frame Steel/Concrete Block Number of Stories 2

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

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

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

N/A

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

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

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>		<u>1972</u>	<u>\$ 25,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	1972	1972	\$ 1,375,843	\$ 34,396	40	\$ 34,396		\$ 1,232,522	4
5	150	1976	1976	1,198,083	29,952	40	29,952		943,488	5
6										6
7										7
8										8
Improvement Type**										
9	Fencing		1970	727		20			727	9
10	Landscaping		1972	51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance		1973	37,155		10-20			37,155	11
12	Door		1974	38,466		20			38,466	12
13	Asphalt Paving		1975	155,856		15			155,856	13
14	Landscaping		1976	57,254		10-15			57,254	14
15	Sewer and Water		1976	26,031		30			26,031	15
16	Plumbing		1972	183,817		25			183,817	16
17	Heating and Electrical		1972	522,443		20			522,443	17
18	Plumbing		1976	262,534		25			262,534	18
19	Heating and Electrical		1976	508,942		20			508,942	19
20	Sprinkler System and Paving		1975	83,460		25			83,460	20
21	Repairs / Roof		1981	107,858		15			107,858	21
22	Building Improvement		1987	819,813	32,792	25	32,792		672,238	22
23	Reroof A & B Roof		1985	85,920		20			85,920	23
24	Parking Lot Lights		1989	3,040		15			3,040	24
25	Reroof / Hot Water		1992	162,867	8,143	20	8,143		126,217	25
26	Washer Repair		1992	3,284		3			3,284	26
27	Site Improvements		1993	101,451	6,764	15	6,764		98,078	27
28	Laundry Renovation		1994	108,852	7,256	15	7,256		97,956	28
29	Paving Parking Lot		1995	66,260	4,417	15	4,417		55,212	29
30	Laundry, Air Conditioner		1996	362,815	30,235	12	30,235		347,702	30
31	Elevator Repair		1997	4,990	249	10	249		4,990	31
32	Tile		1992	7,040		5			7,040	32
33	Elevator Repair		1996	2,212		3			2,212	33
34	Sheeting		1993	3,685		3			3,685	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Site improvement	1998	\$ 2,936	\$ 294	10	\$ 294	\$	\$ 2,793	37
38	Electrical work	1998	2,085	209	10	209		1,985	38
39	Plumbing repair	1998	2,440	244	10	244		2,318	39
40	Boiler repair	1998	4,273	427	10	427		4,057	40
41	Fence	1999	1,000	100	10	100		850	41
42	Air Conditioning Repair	1999	6,284	628	10	628		5,338	42
43	Boiler repair	1999	4,965	497	10	497		4,224	43
44	Doors	1999	4,842	484	10	484		4,114	44
45	Carpeting	1999	1,649	165	10	165		1,402	45
46	Nurses Station	1999	53,554	5,355	10	5,355		44,179	46
47	Wallpaper	2000	840	84	10	84		630	47
48	Vinyl Board	2000	823	82	10	82		615	48
49	Office Compressor	2000	1,205	120	10	120		900	49
50	Fire System	2000	3,441	344	10	344		2,580	50
51	Fence	2000	936	94	10	94		705	51
52	Air Ducts	2000	3,090	309	10	309		2,318	52
53	Service Work	2000	1,573	157	10	157		1,178	53
54	Parking Lot	2000	4,860	486	10	486		3,645	54
55	Circular Pumps	2000	1,079	108	10	108		810	55
56	Boiler repair	2001	5,326	533	10	533		3,464	56
57									57
58	Plumbing	2002	11,756	1,176	10	1,176		6,468	58
59	Air Cleaner	2002	2,020	202	10	202		1,111	59
60	Boiler	2002	5,658	567	10	567		3,118	60
61	HVAC Control	2002	2,800	280	10	280		1,540	61
62	Fire and Smoke Dampers	2002	26,087	2,609	10	2,609		14,349	62
63	Doors	2002	4,155	416	10	416		2,288	63
64	Fireproof Framing	2002	2,730	273	10	273		1,502	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,504,680	\$ 170,447		\$ 170,447	\$	\$ 5,838,183	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,504,680	\$ 170,447		\$ 170,447	\$	\$ 5,838,183	1
2	HVAC	2003	11,370	1,137	10	1,137		5,117	2
3	Plumbing	2003	11,833	1,183	10	1,183		5,324	3
4	Oven repairs	2003	3,020	302	10	302		1,359	4
5	Dishwasher repairs	2003	1,419	142	10	142		639	5
6	Garbage disposal	2003	2,429	243	10	243		1,093	6
7	Freezer doors	2003	5,610	561	10	561		2,525	7
8	Boiler repairs	2003	21,892	2,189	10	2,189		9,851	8
9	Entrance door repairs	2003	13,240	1,324	10	1,324		5,958	9
10	Washing machine repair	2003	1,045	105	10	105		472	10
11	Site improvement	2003	8,252	825	10	825		3,713	11
12									12
13	Fire alarm system	2004	140,676	14,068	10	14,068		49,238	13
14	Water pipes replaced	2004	44,498	4,450	10	4,450		15,575	14
15	Structural work	2004	5,331	534	10	534		1,869	15
16	Windows	2004	29,590	2,960	10	2,960		10,360	16
17	Wall divider	2004	11,280	1,128	10	1,128		3,948	17
18	Front gate and posts	2004	8,025	802	10	802		2,807	18
19									19
20	Various lighting	2005	60,791	6,080	10	6,080		15,200	20
21	Cabinet	2005	1,200	120	10	120		300	21
22	Cabinet	2005	4,900	490	10	490		1,225	22
23	Pavement	2005	6,581	658	10	658		1,645	23
24	Stump removal and excavation	2005	12,600	1,260	10	1,260		3,150	24
25	Fire alarm modification	2005	4,286	428	10	428		1,070	25
26	Iron fence	2005	23,365	2,336	10	2,336		5,840	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,937,913	\$ 213,772		\$ 213,772	\$	\$ 5,986,461	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending:

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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	\$ 158,474	\$ 10,707	\$ 10,707	\$	10	\$ 34,344	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	2,003,986				10	2,003,986	73
74								74
75	TOTALS	\$ 2,162,460	\$ 10,707	\$ 10,707	\$		\$ 2,038,330	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				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 9,125,373	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 224,479	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 224,479	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)	\$ 8,024,791	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	Construction In Process	4,186,945	93
94			94
95		\$ 4,186,945	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$ <u>N/A</u>			3
4	Additions						4
5							5
6	<u>Storage Unit</u>			<u>2,748</u>			6
7	TOTAL			\$ <u>2,748</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 70,839 Description: See attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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

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

Sunny Hill Nursing Home
PROVIDER # 0014076
11/30/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Ice Machine	\$	5,280
Helium tanks		1,549
Other Medical Equipment		6,013
Oxygen Tanks		32,860
Mattress		25,137
		<u>70,839</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)	
TOTAL TRAINED	

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

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

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(2,3)	hrs	\$	4,517	\$ 271,023	\$ 5,814	4,517	\$ 276,837	1
2	Licensed Speech and Language Development Therapist	10A(2,3)	hrs		877	52,645	1,129	877	53,774	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		3,491	209,432	4,493	3,491	213,925	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				105,321		105,321	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			\$	8,885	\$ 533,100	\$ 116,757	8,885	\$ 649,857	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning: 12/01/06

Ending:

11/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	493,765	493,765	15
16	Equipment, at Historical Cost	2,151,581	2,162,460	16
17	Accumulated Depreciation (book methods)	(8,024,791)	(8,024,791)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	4,186,945	4,186,945	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,276,648	\$ 5,287,527	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,276,648	\$ 5,287,527	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	912,312	912,312	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 912,312	\$ 912,312	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 912,312	\$ 912,312	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,364,336	\$ 4,375,215	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,276,648	\$ 5,287,527	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,819,609	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,819,609	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,311,970	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)	\$ 3,311,970	17
	B. Transfers (Itemize):		
18	Interfund Transfers	(2,767,243)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,767,243)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,364,336	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 14,210,464	1
2	Discounts and Allowances for all Levels	563,320	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,773,784	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,140,150	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,140,150	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,431	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	139,210	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,215	19
20	Radiology and X-Ray	10,249	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 173,105	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Sundries</u>	266	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 266	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,087,305	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,020,516	31
32	Health Care	8,332,540	32
33	General Administration	846,026	33
	B. Capital Expense		
34	Ownership	298,159	34
	C. Ancillary Expense		
35	Special Cost Centers	113,844	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,775,335	40
41	Income before Income Taxes (line 30 minus line 40)**	3,311,970	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,311,970	43

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

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

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

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

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

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	2,059	2,080	\$ 78,030	\$ 37.51	1
2	Assistant Director of Nursing	1,881	2,080	63,653	30.60	2
3	Registered Nurses	37,393	40,297	1,114,600	27.66	3
4	Licensed Practical Nurses	65,666	70,819	1,565,756	22.11	4
5	CNAs & Orderlies	235,432	253,886	3,434,131	13.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	15,118	16,640	286,251	17.20	8
9	Activity Director					9
10	Activity Assistants	15,240	16,640	264,738	15.91	10
11	Social Service Workers	9,865	10,400	255,309	24.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	51,535	54,620	755,237	13.83	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	67,148	73,703	924,087	12.54	18
19	Laundry	17,850	19,592	245,644	12.54	19
20	Administrator	1,968	2,080	86,986	41.82	20
21	Assistant Administrator	1,904	2,080	62,248	29.93	21
22	Other Administrative	1,823	2,080	47,697	22.93	22
23	Office Manager					23
24	Clerical	18,926	20,800	389,765	18.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	543,808	587,797	\$ 9,574,132 *	\$ 16.29	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	419	\$ 16,780	1(3)	35
36	Medical Director	Monthly	3,500	9(3)	36
37	Medical Records Consultant	48	2,190	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	19,099	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	467	\$ 41,569		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	921	\$ 45,082	10(3)	50
51	Licensed Practical Nurses	4,291	171,491	10(3)	51
52	Certified Nurse Assistants/Aides	427	9,968	10(3)	52
53	TOTAL (lines 50 - 52)	5,639	\$ 226,541		53

SEE ACCOUNTANTS' COMPILATION REPORT

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		
<u>Karen Sobero</u>	<u>Administrator</u>		\$ <u>86,986</u>	<u>Workers' Compensation Insurance</u>	\$ _____	<u>IDPH License Fee</u>	\$ <u>1,990</u>		
<u>Becky Halderson</u>	<u>Asst. Administrator</u>		<u>62,248</u>	<u>Unemployment Compensation Insurance</u>	_____	<u>Advertising: Employee Recruitment</u>	_____		
<u>Ellen Gerard</u>	<u>Other Administrative</u>		<u>47,697</u>	<u>FICA Taxes</u>	<u>16,159</u>	<u>Health Care Worker Background Check</u>	_____		
				<u>Employee Health Insurance</u>	<u>28,840</u>	(Indicate # of checks performed <u>230</u>)	<u>2,296</u>		
				<u>Employee Meals</u>	_____	<u>Patient Background Checks</u>	_____		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>	<u>18,582</u>		_____		
				<u>Uniforms</u>	<u>60,756</u>	<u>See Schedule 21A</u>	<u>20,650</u>		
				<u>Employee Morale</u>	<u>11,286</u>		_____		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>196,931</u>				_____		
(List each licensed administrator separately.)							_____		
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount	
<u>N/A</u>			\$ _____			\$ _____	<u>Out-of-State Travel</u>	\$ _____	
				<u>Allocation from County - Worker's Comp</u>		<u>452,091</u>	<u>N/A</u>	_____	
				<u>Allocation from County - FICA</u>		<u>720,095</u>		_____	
				<u>Allocation from County - Health Insurance</u>		<u>2,294,250</u>	<u>In-State Travel</u>	_____	
				<u>Allocation from County - IMRF</u>		<u>916,074</u>	<u>N/A</u>	_____	

TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>4,518,133</u>	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)								\$ <u>20,139</u>	
C. Professional Services			TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)			
Vendor/Payee	Type			Amount					
<u>Duane Morris, LLP</u>	<u>Legal</u>			\$ <u>4,810</u>					
<u>UHC/Accumed Systems</u>	<u>Computer</u>			<u>3,588</u>					
<u>Health Data Systems</u>	<u>Computer</u>			<u>13,214</u>					
<u>McGladrey & Pullen</u>	<u>Accounting</u>			<u>10,250</u>					
<u>RSM McGladrey</u>	<u>Accounting</u>			<u>7,448</u>					
<u>Medifax-EDI</u>	<u>Medical Billing</u>			<u>1,124</u>					
<u>Mutual of Omaha</u>	<u>Medicare Billing</u>			<u>2,010</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ _____	TOTAL			\$ _____	Entertainment Expense	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ <u>42,444</u>						
							(agree to Sch. V, line 24, col. 8)		
							TOTAL		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Sunny Hill Nursing Home

Provider #: 0014076

12/1/2006 to 11/30/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Subtotal	42,444
Total (agree to Schedule V, line 19, column 3)	<u>42,444</u>
Allocated from Will County	967,670
Total (agree to Schedule V, line 19, column 8)	<u><u>1,010,114</u></u>

F. Dues, Fees, Subscriptions and Promotions

County Nursing Home Assn dues	2,220
Illinois Health Care Assn	12,144
Miscellaneous Subscriptions	5,278
Yellow Page Advertising	<u>1,008</u>
	<u><u>20,650</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2							N/A													
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home of Will County

0014076

Report Period Beginning:

12/01/06

Ending:

11/30/07

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$8,585; City NH Assn. - \$2,220
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 173,625 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 164,250
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,431
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Wermer, Rodgers, Daran & Ryan 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. Audit is not yet complete
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT