



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

# 0014076 Report Period Beginning: 12/01/07 Ending: 11/30/08

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 N/A

	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	300	Skilled (SNF)	300	109,800	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	300	TOTALS	300	109,800	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	47,813	11,681	16,741	76,235	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,813	11,681	16,741	76,235	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.43%

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 300 and days of care provided 8,738

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: 11/30/2008

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

Facility Name & ID Number Sunny Hill Nursing Home of Will Co # 0014076 Report Period Beginning: 12/01/07 Ending: 11/30/08

**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
	<b>A. General Services</b>										
1	Dietary	703,696	28,170	22,474	754,340		754,340		754,340		1
2	Food Purchase		535,586		535,586		535,586	(5,189)	530,397		2
3	Housekeeping	925,561	77,575		1,003,136		1,003,136		1,003,136		3
4	Laundry	246,035	22,495		268,530		268,530		268,530		4
5	Heat and Other Utilities			341,084	341,084		341,084		341,084		5
6	Maintenance		27	136,300	136,327		136,327	645,535	781,862		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,875,292	663,853	499,858	3,039,003		3,039,003	640,346	3,679,349		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,000	8,000		8,000		8,000		9
10	Nursing and Medical Records	6,619,455	524,656	373,536	7,517,647		7,517,647	(18,960)	7,498,687		10
10a	Therapy		6,531	651,200	657,731		657,731		657,731		10a
11	Activities	268,633			268,633		268,633		268,633		11
12	Social Services	273,194			273,194		273,194		273,194		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	7,161,282	531,187	1,032,736	8,725,205		8,725,205	(18,960)	8,706,245		16
	<b>C. General Administration</b>										
17	Administrative	210,502			210,502		210,502		210,502		17
18	Directors Fees										18
19	Professional Services			52,155	52,155		52,155	1,022,624	1,074,779		19
20	Dues, Fees, Subscriptions & Promotions			26,436	26,436		26,436	(4,746)	21,690		20
21	Clerical & General Office Expenses	375,444	21,034	38,791	435,269		435,269	69,697	504,966		21
22	Employee Benefits & Payroll Taxes			143,666	143,666		143,666	4,720,738	4,864,404		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,704	5,704		5,704		5,704		24
25	Other Admin. Staff Transportation			10,954	10,954		10,954		10,954		25
26	Insurance-Prop.Liab.Malpractice							488,936	488,936		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	585,946	21,034	277,706	884,686		884,686	6,297,249	7,181,935		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	9,622,520	1,216,074	1,810,300	12,648,894		12,648,894	6,918,635	19,567,529		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	
	<b>D. Ownership</b>											
30	Depreciation			205,124	205,124		205,124	611	205,735			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71	71		71	(71)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,470	1,470		1,470		1,470			34
35	Rent-Equipment & Vehicles			69,098	69,098		69,098		69,098			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			275,763	275,763		275,763	540	276,303			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		239,686		239,686		239,686		239,686			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):* <b>Non-allowable cost</b>			5,780	5,780		5,780	(5,780)				43
44	<b>TOTAL Special Cost Centers</b>		239,686	170,480	410,166		410,166	(5,780)	404,386			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	9,622,520	1,455,760	2,256,543	13,334,823		13,334,823	6,913,395	20,248,218			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.

SEE ACCOUNTANTS' COMPILATION 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	(5,189)	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	611	30		9
10	Interest and Other Investment Income	(71)	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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(39,121)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (43,770)		\$	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)	6,957,165		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 6,957,165		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 6,913,395		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Nursing Home of Will Co

ID# 0014076

Report Period Beginning: 12/01/07

Ending: 11/30/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Chamber of Commerce Dues	\$ (389)	20	1
2	Lab Services	(5,060)	43	2
3	Disallow non-allowable radiology services	(720)	43	3
4	Disallow IHCA PAC dues	(4,357)	20	4
5	Reclass R&M per HFS regulations	(9,635)	6	5
6	Disallow non-allowable radiology services	(18,960)	10	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>	(39,121)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

12/01/07

Ending:

11/30/08

## 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	(5,189)	0	0	0	0	0	0	0	0	0	0	(5,189)	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	(9,635)	655,170	0	0	0	0	0	0	0	0	0	645,535	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(14,824)</b>	<b>655,170</b>	<b>0</b>	<b>640,346</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	(18,960)	0	0	0	0	0	0	0	0	0	0	(18,960)	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>(18,960)</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>(18,960)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	1,022,624	0	0	0	0	0	0	0	0	0	1,022,624	19
20	Fees, Subscriptions & Promotions	(4,746)	0	0	0	0	0	0	0	0	0	0	(4,746)	20
21	Clerical & General Office Expenses	0	69,697	0	0	0	0	0	0	0	0	0	69,697	21
22	Employee Benefits & Payroll Taxes	0	4,720,738	0	0	0	0	0	0	0	0	0	4,720,738	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	488,936	0	0	0	0	0	0	0	0	0	488,936	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(4,746)</b>	<b>6,301,995</b>	<b>0</b>	<b>6,297,249</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(38,530)</b>	<b>6,957,165</b>	<b>0</b>	<b>6,918,635</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Hill Nursing Home of Will Co # 0014076 Report Period Beginning: 12/01/07 Ending: 11/30/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	611	0	0	0	0	0	0	0	0	0	0	611	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(71)	0	0	0	0	0	0	0	0	0	0	(71)	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>540</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>540</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	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):*	(5,780)	0	0	0	0	0	0	0	0	0	0	(5,780)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(5,780)</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>(5,780)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(43,770)</b>	<b>6,957,165</b>	<b>0</b>	<b>6,913,395</b>	<b>45</b>								

**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
Will County	100	N/A		Will County	Joliet	Government

**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	6 Maintenance	\$	Will County	100.00%	\$ 655,170	\$ 655,170	1
2	V	19 Professional Services		Will County	100.00%	1,022,624	1,022,624	2
3	V	21 Film Processing		Will County	100.00%	24,628	24,628	3
4	V	21 Telephone		Will County	100.00%	45,069	45,069	4
5	V	22 Employee Benefits		Will County	100.00%	4,720,738	4,720,738	5
6	V	26 Insurance		Will County	100.00%	488,936	488,936	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 6,957,165	\$ * 6,957,165	14

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

Facility Name & ID Number Sunny Hill Nursing Home of Will Co # 0014076 Report Period Beginning: 12/01/07 Ending: 11/30/08

## 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	See attached list of	County board									4
5	board members	member	Administrative	0.00	None	<1 hour	0.00	N/A	None	N/A	5
6	No services have been provided to the nursing home by board members										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

SEE ACCOUNTANTS' COMPILATION REPORT

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

# 0014076 Report Period Beginning: 12/01/07

Ending: 11/30/08

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	\$ 655,170	\$ 1	\$ 655,170	1
2	19	Professional services	Number of warrants	N/A	1	1,022,624	1	1,022,624	2
3	21	Film processing	Estimated time	N/A	1	24,628	1	24,628	3
4	21	Telephone	Direct cost	N/A	1	45,069	1	45,069	4
5	22	Employee Benefits	Direct cost	N/A	1	4,720,738	1	4,720,738	5
6	26	Insurance	Direct cost	N/A	1	488,936	1	488,936	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					\$ 6,957,165	\$	\$ 6,957,165	25

SEE ACCOUNTANTS' COMPILATION REPORT



**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 2007 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 2008 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:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	_____	12
<b>Not applicable - county does not pay real estate taxes.</b>			
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Sunny Hill Nursing Home of Will Co 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 2007 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 2007.

(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>	\$ <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>
<b>TOTALS</b>		\$ <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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

# 0014076 Report Period Beginning:

12/01/07 Ending:

11/30/08

**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	<b>TOTALS</b>			<b>\$ 25,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Sunny Hill Nursing Home of Will Co

# 0014076

Report Period Beginning:

12/01/07

Ending:

11/30/08

**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	\$	\$ 1,266,918	4
5	150	1976	1976	1,198,083	29,952	40	29,952		973,440	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
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		705,030	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		134,360	25
26	Washer Repair		1992	3,284		3			3,284	26
27	Site Improvements		1993	101,451	3,373	15	3,373		101,451	27
28	Laundry Renovation		1994	108,852	7,256	15	7,256		105,212	28
29	Paving Parking Lot		1995	66,260	4,417	15	4,417		59,629	29
30	Laundry, Air Conditioner		1996	362,815	15,113	12	15,113		362,815	30
31	Elevator Repair		1997	4,990		10			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 &amp; ID Number Sunny Hill Nursing Home of Will Co

# 0014076

Report Period Beginning:

12/01/07

Ending:

11/30/08

## 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	\$ 143	10	\$ 143	\$	\$ 2,936	37
38	Electrical work	1998	2,085	100	10	100		2,085	38
39	Plumbing repair	1998	2,440	122	10	122		2,440	39
40	Boiler repair	1998	4,273	216	10	216		4,273	40
41	Fence	1999	1,000	100	10	100		950	41
42	Air Conditioning Repair	1999	6,284	628	10	628		5,966	42
43	Boiler repair	1999	4,965	497	10	497		4,721	43
44	Doors	1999	4,842	484	10	484		4,598	44
45	Carpeting	1999	1,649	165	10	165		1,567	45
46	Nurses Station	1999	53,554	5,355	10	5,355		49,534	46
47	Wallpaper	2000	840	84	10	84		714	47
48	Vinyl Board	2000	823	82	10	82		697	48
49	Office Compressor	2000	1,205	120	10	120		1,020	49
50	Fire System	2000	3,441	344	10	344		2,924	50
51	Fence	2000	936	94	10	94		799	51
52	Air Ducts	2000	3,090	309	10	309		2,627	52
53	Service Work	2000	1,573	157	10	157		1,335	53
54	Parking Lot	2000	4,860	486	10	486		4,131	54
55	Circular Pumps	2000	1,079	108	10	108		918	55
56	Boiler repair	2001	5,326	533	10	533		3,997	56
57									57
58	Plumbing	2002	11,756	1,176	10	1,176		7,644	58
59	Air Cleaner	2002	2,020	202	10	202		1,313	59
60	Boiler	2002	5,658	567	10	567		3,685	60
61	HVAC Control	2002	2,800	280	10	280		1,820	61
62	Fire and Smoke Dampers	2002	26,087	2,609	10	2,609		16,958	62
63	Doors	2002	4,155	416	10	416		2,704	63
64	Fireproof Framing	2002	2,730	273	10	273		1,775	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,504,680	\$ 151,092		\$ 151,092	\$	\$ 5,989,275	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Sunny Hill Nursing Home of Will Co

# 0014076

Report Period Beginning:

12/01/07

Ending:

11/30/08

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,504,680	\$ 151,092		\$ 151,092	\$	\$ 5,989,275	1
2	HVAC	2003	11,370	1,137	10	1,137		6,254	2
3	Plumbing	2003	11,833	1,183	10	1,183		6,507	3
4	Oven repairs	2003	3,020	302	10	302		1,661	4
5	Dishwasher repairs	2003	1,419	142	10	142		781	5
6	Garbage disposal	2003	2,429	243	10	243		1,336	6
7	Freezer doors	2003	5,610	561	10	561		3,086	7
8	Boiler repairs	2003	21,892	2,189	10	2,189		12,040	8
9	Entrance door repairs	2003	13,240	1,324	10	1,324		7,282	9
10	Washing machine repair	2003	1,045	105	10	105		577	10
11	Site improvement	2003	8,252	825	10	825		4,538	11
12									12
13	Fire alarm system	2004	140,676	14,068	10	14,068		63,306	13
14	Water pipes replaced	2004	44,498	4,450	10	4,450		20,025	14
15	Structural work	2004	5,331	534	10	534		2,403	15
16	Windows	2004	29,590	2,960	10	2,960		13,320	16
17	Wall divider	2004	11,280	1,128	10	1,128		5,076	17
18	Front gate and posts	2004	8,025	802	10	802		3,609	18
19									19
20	Various lighting	2005	60,791	6,080	10	6,080		21,280	20
21	Cabinet	2005	1,200	120	10	120		420	21
22	Cabinet	2005	4,900	490	10	490		1,715	22
23	Pavement	2005	6,581	658	10	658		2,303	23
24	Stump removal and excavation	2005	12,600	1,260	10	1,260		4,410	24
25	Fire alarm modification	2005	4,286	428	10	428		1,498	25
26		2005	23,365	2,336	10	2,336		8,176	26
27	R&M Reclass - Remove & Replace concrete sidewalk for								27
28	front entrance to facility	2008	7,059		10	353	353	353	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,944,972	\$ 194,417		\$ 194,770	\$ 353	\$ 6,181,231	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 Co

# 0014076

Report Period Beginning:

12/01/07

Ending:

11/30/08

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	\$ 45,051	71
72	Current Year Purchases	2,576		258	258	10	258	72
73	Fully Depreciated Assets	2,003,986					2,003,986	73
74								74
75	TOTALS	\$ 2,165,036	\$ 10,707	\$ 10,965	\$ 258		\$ 2,049,295	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										77
78	N/A									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)	\$ 9,135,008	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 205,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,735	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 611	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,230,526	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 Progress	7,412,091	93
94			94
95		\$ 7,412,091	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:			\$			3
4	Additions						4
5							5
6	Storage Unit			1,470			6
7	TOTAL			\$ 1,470			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: \$ 69,098 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			N/A		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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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

12/01/07 - 11/30/08

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Helium tanks	\$	74
Ice Machine		2,700
Other Medical Equipment		9,224
Dietary Equipment		6,029
Mattress		14,743
Oxygen Tanks		35,571
Activities Equipment		757
		<hr/>
		69,098
		<hr/>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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>	

- (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	\$	6,061	\$ 363,684	\$ 3,647	6,061	\$ 367,331	1
2	Licensed Speech and Language Development Therapist	10A(2,3)	hrs		590	35,399	355	590	35,754	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		4,202	252,117	2,529	4,202	254,646	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				239,686		239,686	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	10,853	\$ 651,200	\$ 246,217	10,853	\$ 897,417	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 &amp; ID Number Sunny Hill Nursing Home of Will Co

# 0014076

Report Period Beginning: 12/01/07

Ending:

11/30/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
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	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$	\$	10
	<b>B. Long-Term Assets</b>			
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	500,824	15
16	Equipment, at Historical Cost	2,151,581	2,165,036	16
17	Accumulated Depreciation (book methods)	(8,229,915)	(8,230,526)	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 (spec <u>Const in Progress</u> )	7,412,091	7,412,091	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 8,296,670	\$ 8,316,573	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 8,296,670	\$ 8,316,573	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
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	961,601	961,601	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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 961,601	\$ 961,601	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 961,601	\$ 961,601	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 7,335,069	\$ 7,354,972	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 8,296,670	\$ 8,316,573	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,364,336</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>4,364,336</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>3,674,406</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>3,674,406</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Interfund Transfers</b>	<b>(703,673)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(703,673)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>7,335,069</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,642,345	1
2	Discounts and Allowances for all Levels	735,530	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 15,377,875	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,392,188	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,392,188	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,189	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	199,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,543	19
20	Radiology and X-Ray	14,620	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 237,824	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Sundry</u>	1,342	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,342	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 17,009,229	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,039,003	31
32	Health Care	8,725,205	32
33	General Administration	884,686	33
<b>B. Capital Expense</b>			
34	Ownership	275,763	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	245,466	35
36	Provider Participation Fee	164,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,334,823	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	3,674,406	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 3,674,406	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 Co**

# **0014076**

Report Period Beginning:

**12/01/07**

Ending:

**11/30/08**

**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	2,029	2,153	\$ 83,200	\$ 38.64	1
2	Assistant Director of Nursing	2,145	2,360	74,402	31.53	2
3	Registered Nurses	33,635	38,996	1,110,982	28.49	3
4	Licensed Practical Nurses	75,826	84,996	1,935,362	22.77	4
5	CNAs & Orderlies	202,569	226,838	3,162,124	13.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,866	14,299	253,385	17.72	8
9	Activity Director					9
10	Activity Assistants	14,918	16,390	268,633	16.39	10
11	Social Service Workers	10,283	10,802	273,194	25.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	46,813	49,417	703,696	14.24	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	62,215	71,638	925,561	12.92	18
19	Laundry	16,537	19,043	246,035	12.92	19
20	Administrator	2,044	2,100	90,459	43.08	20
21	Assistant Administrator	2,283	2,413	74,402	30.83	21
22	Other Administrative	1,654	1,932	45,641	23.62	22
23	Office Manager					23
24	Clerical	17,497	19,453	375,444	19.30	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)	503,314	562,830	\$ 9,622,520 *	\$ 17.10	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	561	\$ 22,474	1(3)	35
36	Medical Director	Monthly	8,000	9(3)	36
37	Medical Records Consultant	46	2,085	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,239	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)	607	\$ 47,798		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	895	\$ 43,802	10(3)	50
51	Licensed Practical Nurses	4,169	166,625	10(3)	51
52	Certified Nurse Assistants/Aides	415	9,685	10(3)	52
53	TOTAL (lines 50 - 52)	5,479	\$ 220,112		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	
Karen Sobero	Administrator	0	\$ 90,459	Workers' Compensation Insurance	\$	IDPH License Fee	\$ 1,990	
Becky Halderson	Asst. Administrator	0	74,402	Unemployment Compensation Insurance		Advertising: Employee Recruitment	1,365	
Ellen Gerard	Other Administrative	0	45,641	FICA Taxes	16,277	Health Care Worker Background Check (Indicate # of checks performed <u>200</u> )	2,000	
				Employee Health Insurance	32,122	Patient Background Checks		
				Employee Meals		County Nursing Home Assn Dues	1,930	
				Illinois Municipal Retirement Fund (IMRF)*	18,824	Illinois Healthcare Association	12,144	
				Uniforms	68,043	MW Automated Time System License	5,972	
				Employee Morale	8,400	Miscellaneous Dues & Subscriptions	1,035	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 210,502	Allocation from County - Worker's Comp	551,090	Less: PAC Dues	(4,357)	
B. Administrative - Other				Allocation from County - FICA	721,865	Less: Public Relations Expense	(389)	
Description			Amount	Allocation from County - Health Insurance	2,535,728	Non-allowable advertising	( )	
N/A			\$	Allocation from County - IMRF	912,055	Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,864,404	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,690
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount	N/A		\$		
Duane Morris, LLP	Legal		\$ 13,260				Out-of-State Travel	\$
UHC/Accumed Systems	Computer		3,485				N/A	
Health Data Systems	Computer		13,249				In-State Travel	
McGladrey & Pullen	Accounting		11,100				N/A	
RSM McGladrey	Accounting		100				Seminar Expense	
Medifax-EDI	Medical Billing		2,893				See Attached Schedule	5,704
Mutual of Omaha	Medicare Billing		8,068				Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 52,155	TOTAL		\$	TOTAL	\$ 5,704

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Sunny Hill Nursing Home**

**Provider #:** 0014076  
**12/1/2007 to** 11/30/2008

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Subtotal	52,155
Total (agree to Schedule V, line 19, column 3)	<u>52,155</u>
Allocated from Will County	1,022,624
Total (agree to Schedule V, line 19, column 8)	<u><u>1,074,779</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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2005					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Sunny Hill Nursing Home of Will Co

# 0014076

Report Period Beginning:

12/01/07

Ending:

11/30/08

**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 - \$12,144; County NH Assn. - \$1,930
- (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? Yes  
What was the average life used for new equipment added during this period? 10 yr.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 125,186 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. \$ 164,700  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 5,189
- (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: McGladrey & Pullen LLP 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