

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning: 12-01-08 Ending: 11-30-09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 106

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	17,291	11,618	4,215	33,124	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,291	11,618	4,215	33,124	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.61%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 12-01-1966

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 106 and days of care provided 3,883

Medicare Intermediary cms

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 11-30

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-08 Ending: 11-30-09

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	312,739	27,402	5,378	345,519		345,519		345,519		1
2	Food Purchase		298,982		298,982	(46,300)	252,682	(16,211)	236,471		2
3	Housekeeping	231,073	43,294		274,367		274,367		274,367		3
4	Laundry	37,974	12,265		50,239		50,239		50,239		4
5	Heat and Other Utilities			192,235	192,235		192,235	(2,289)	189,946		5
6	Maintenance	75,266	93,379	2,400	171,045		171,045		171,045		6
7	Other (specify):*										7
8	TOTAL General Services	657,052	475,322	200,013	1,332,387	(46,300)	1,286,087	(18,500)	1,267,587		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,794,467	154,672	128,084	2,077,223		2,077,223	(27,144)	2,050,079		10
10a	Therapy	26,444	169,067	484,437	679,948	(653,504)	26,444		26,444		10a
11	Activities	62,544	15,203		77,747		77,747		77,747		11
12	Social Services	118,240	4,000	7,503	129,743		129,743		129,743		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,001,695	342,942	632,024	2,976,661	(653,504)	2,323,157	(27,144)	2,296,013		16
	C. General Administration										
17	Administrative	68,067	1,854	36,508	106,429		106,429		106,429		17
18	Directors Fees										18
19	Professional Services			118,741	118,741		118,741	7,355	126,096		19
20	Dues, Fees, Subscriptions & Promotions			42,403	42,403		42,403	(34,662)	7,741		20
21	Clerical & General Office Expenses	65,629	19,002	14,361	98,992		98,992		98,992		21
22	Employee Benefits & Payroll Taxes			485,267	485,267	46,300	531,567		531,567		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,881	3,881		3,881		3,881		24
25	Other Admin. Staff Transportation		1,767	12,905	14,672		14,672		14,672		25
26	Insurance-Prop.Liab.Malpractice			52,538	52,538		52,538		52,538		26
27	Other (specify):*			15,728	15,728		15,728	(15,728)			27
28	TOTAL General Administration	133,696	22,623	782,332	938,651	46,300	984,951	(43,035)	941,916		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,792,443	840,887	1,614,369	5,247,699	(653,504)	4,594,195	(88,679)	4,505,516		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			143,053	143,053		143,053		143,053			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			143,053	143,053		143,053		143,053			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					653,504	653,504		653,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		5,931		5,931		5,931	(5,931)				41
42	Provider Participation Fee			58,512	58,512		58,512		58,512			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,931	58,512	64,443	653,504	717,947	(5,931)	712,016			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,792,443	846,818	1,815,934	5,455,195		5,455,195	(94,610)	5,360,585			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(16,211)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,289)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,280)	19		17
18	Fines and Penalties	(15,728)	27		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	(29,179)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,483)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,170)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (70,170)		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.			\$	38
39	special services see page 16	x		484,437	10a 39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology			33,878	10a 42
43	Prescription Drugs			135,189	10a 43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 653,504	47

BHF USE ONLY

48		49		50		51		52
----	--	----	--	----	--	----	--	----

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12-01-08

Ending: 11-30-09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	recovery of medical supplies sold to residents	\$ (27,144)	10	1
2				2
3	coffee and gift shop	(5,931)	41	3
4				4
5	accrued professional fees 11-30-08	8,635	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(24,440)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12-01-08

Ending:

11-30-09

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

	Operating Expenses	PAGES	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	(16,211)	0	0	0	0	0	0	0	0	0	0	(16,211)	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	(2,289)	0	0	0	0	0	0	0	0	0	0	(2,289)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,500)	0	(18,500)	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	(27,144)	0	0	0	0	0	0	0	0	0	0	(27,144)	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	TOTAL Health Care and Programs	(27,144)	0	(27,144)	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	7,355	0	0	0	0	0	0	0	0	0	0	7,355	19
20	Fees, Subscriptions & Promotions	(34,662)	0	0	0	0	0	0	0	0	0	0	(34,662)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(15,728)	0	0	0	0	0	0	0	0	0	0	(15,728)	27
28	TOTAL General Administration	(43,035)	0	(43,035)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(88,679)	0	(88,679)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12-01-08 Ending:

11-30-09

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,931)	0	0	0	0	0	0	0	0	0	0	(5,931)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(5,931)	0	0	0	0	0	0	0	0	0	0	(5,931)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(94,610)	0	0	0	0	0	0	0	0	0	0	(94,610)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Menard County, Illinois	100%	none		Countryside Estates of the County	Petersburg, Illinois	independent living facility
				totally owned by Menard County		
				Sunny Acres Nursing Home		

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

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

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

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-08 Ending: 11-30-09

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	none								\$ none	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ none	13

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-08

Ending: 11-30-09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-08

Ending:

11-30-09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	none					\$	\$			\$								
2																		
3																		
4																		
5																		
Working Capital																		
6	none																	
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10	none																	
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-08

Ending:

11-30-09

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-08

Ending:

11-30-09

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	58		1966	1966	\$ 526,787	\$ (6,589)	40	\$ (6,589)	\$	\$ 526,787	4
5	38		1977	1977	568,714	14,218	40	14,218		454,975	5
6			1984	1984	61,842	2,061	30	2,061		52,560	6
7	10		1993	1993	654,160	16,354	40	16,354		264,390	7
8			1995	1995	68,999	3,450	20	3,450		48,300	8
	Improvement Type**										
9		generator		1980	28,901		10			28,901	9
10		fire alarm system		1981	9,805		10			9,805	10
11		none		1982							11
12		gazebo and floor coverings		1983	12,750		20-23			12,750	12
13		flooring, phone, and paging systems, air conditioner		1984	30,885		10-25			30,885	13
14		sun room, remodelling, wall paper		1985	7,061		5-30			7,061	14
15		kitchen remodelling, wallpaper, parking lot, nightlight, etc		1986	36,333		5-25			36,333	15
16		boiler repair, sprinkler system, office remodelling		1987	17,193		5-25			17,193	16
17		roof, chimney, carpeting, sprinkler system		1988	147,826		5-25			147,826	17
18		compressor, canopy, carport		1989	6,472		15			6,472	18
19		asbestos removal, flooring, water heater, landscaping, canopy		1990	28,642		5-15			28,642	19
20		main air conditioning unit		1991	5,194		15			5,194	20
21		none		1992							21
22		new lagoon, tiling, hot wate heater, aviary		1993	223,851		13			223,851	22
23		fill old lagoon, flooring, wallpaper, and signs		1994	49,671		12			49,671	23
24		major boiler repair, air conditioners, ceiling tile replacement		1995	10,685		5-10			10,685	24
25		special needs unit, resident walking gardens, vinyl soffets		1996	139,517	437	5-30	437		71,635	25
26		donor recognition,wall, remodelling, draperies, and shades		1997	20,798		5-10			20,798	26
27		major boiler repair, air conditioners, ceiling tile replacement		1998	21,699		5			21,699	27
28		two commercial water hearters, entrybath, rooftop		1999	41,844	645	7-10	645		37,885	28
29		plumbing, improvements, stuctural improvement		2000	18,896		5			18,896	29
30		plumbing, electrical, boiler rehabilitation		2001	22,162		5			22,162	30
31		structural improvements, sewer lines and walls		2002	77,846	5,618	10-15	5,618		40,262	31
32		seal parking lot, fences improvements		2003	16,153	883	5-10	883		12,322	32
33		flooring, alarm systems, office remodelling		2004	67,361	5,532	10-20	5,532		30,497	33
34		kitchen tile and ceiling, carpeting, drapes, circuit improvements		2005	17,158	1,715	10	1,715		7,718	34
35		entrance improvements, wiring cable system, front doors		2006	45,926	5,146	10-20	5,146		16,771	35
36		carpeting, vinyl flooring		2007	13,077	1,868	7	1,868		4,670	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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	sprinkler system in progress	2007	\$ 6,128	\$ 409	15	\$ 409	\$	\$ 1,059	37
38	front walk and handrails	2007	19,000	950	20	950		2,299	38
39	hot water heater	2007	3,823	546	7	546		1,229	39
40	foam roofing system	2007	141,519	7,076	20	7,076		15,921	40
41	draft inducer and heater	2007	4,577	654	7	654		1,798	41
42	lockinvar water heater	2007	5,292		7				42
43	extend sprinkler system	2008	169,566	8,478	20	8,478		11,304	43
44	replace boiler and cooling system	2009	388,232	15,098	15	15,098		15,098	44
45	alarm system for building	2009	30,000	333	15	333		333	45
46	bath entry	2009	5,460	228	10	228		228	46
47	back flow preventer	2009	3,602	86	7	86		86	47
48	vinyl flooring	2009	3,406	284	5	284		284	48
49	frame up pictures	2009	3,842	640	5	640		640	49
50	air unit compressor	2009	4,447	296	5	296		296	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,787,102	\$ 86,416		\$ 86,416	\$	\$ 2,318,171	70

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-08

Ending:

11-30-09

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	\$ 376,544	\$ 43,165	\$ 43,165	\$	3-20	\$ 237,984	71
72	Current Year Purchases	48,280	1,492	1,492		4-7	1,492	72
73	Fully Depreciated Assets	628,892	1,831	1,831		5-20	628,892	73
74								74
75	TOTALS	\$ 1,053,716	\$ 46,488	\$ 46,488	\$		\$ 868,368	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	facility operations	1989 van	1989	\$ 22,320	\$	\$			\$ 22,320	76
77	facility operations	2006 ford supreme van	2006	44,625	8,925	8,925		4	33,469	77
78	facility operations	pickup truck	2008	6,120	1,224	1,224		5	1,428	78
79								5		79
80	TOTALS			\$ 73,065	\$ 10,149	\$ 10,149	\$		\$ 57,217	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)	\$ 4,938,883	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 143,053	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,053	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)	\$ 3,243,756	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ none			7

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

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ none	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$ none
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.

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&2and3	hrs	\$		\$ 194,523	\$ 13,671		\$ 208,194	1
2	Licensed Speech and Language Development Therapist	10a&2and3	hrs			49,352	3,455		52,807	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a&2and3	hrs			240,562	16,752		257,314	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				135,189		135,189	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	TOTAL			\$		\$ 484,437	\$ 169,067		\$ 653,504	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Sunny Acres Nursing Home# 0005009Report Period Beginning: 12-01-08Ending: 11-30-09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11-30-09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 959,116	\$ 1,345,429	1
2	Cash-Patient Deposits	112,690	118,690	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>168,429</u>)	984,425	990,764	3
4	Supply Inventory (priced at <u>fifo</u>)	18,000	21,517	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,290	1,289	7
8	Accounts Receivable (owners or related parties)	3,114	3,114	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,078,635	\$ 2,480,803	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,816,510		12
13	Land			13
14	Buildings, at Historical Cost	3,787,102	6,163,223	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,126,781	1,218,544	16
17	Accumulated Depreciation (book methods)	(3,243,756)	(4,283,817)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,562,031	1,562,031	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,048,668	\$ 4,659,981	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,127,303	\$ 7,140,784	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 607,821	\$ 615,302	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	112,690	118,690	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,387	152,387	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)	\$ 872,898	\$ 886,379	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)	\$ 872,898	\$ 886,379	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,254,405	\$ 6,254,405	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,127,303	\$ 7,140,784	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,895,942	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,895,942	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	418,463	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)	\$ 418,463	17
	B. Transfers (Itemize):		
18	return of contributed capital to the general fund	(60,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (60,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,254,405	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunny Acres Nursing Home# 0005009Report Period Beginning: 12-01-08Ending: 11-30-09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,798,268	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,798,268	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,897,676	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,897,676	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	8,388	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	16,211	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,144	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 51,743	23
D. Non-Operating Revenue			
24	Contributions	24,894	24
25	Interest and Other Investment Income***	101,077	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 125,971	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,873,658	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,332,387	31
32	Health Care	2,976,661	32
33	General Administration	938,651	33
B. Capital Expense			
34	Ownership	143,053	34
C. Ancillary Expense			
35	Special Cost Centers	5,931	35
36	Provider Participation Fee	58,512	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,455,195	40
41	Income before Income Taxes (line 30 minus line 40)**	418,463	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 418,463	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.

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-08

Ending:

11-30-09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,087	1,299	\$ 34,630	\$ 26.66	1
2	Assistant Director of Nursing	1,293	1,637	37,425	22.86	2
3	Registered Nurses	5,132	5,767	143,962	24.96	3
4	Licensed Practical Nurses	29,431	31,040	579,177	18.66	4
5	CNAs & Orderlies	86,730	91,778	962,262	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,779	2,013	24,757	12.30	9
10	Activity Assistants	3,621	4,076	37,787	9.27	10
11	Social Service Workers	7,473	8,386	118,240	14.10	11
12	Dietician					12
13	Food Service Supervisor	1,939	2,069	29,930	14.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,684	8,190	88,202	10.77	15
16	Dishwashers	22,447	22,992	194,607	8.46	16
17	Maintenance Workers	6,190	7,159	75,266	10.51	17
18	Housekeepers	22,804	24,283	231,073	9.52	18
19	Laundry	3,952	4,350	37,974	8.73	19
20	Administrator	1,420	1,682	68,067	40.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,670	4,136	65,629	15.87	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)	1,597	1,738	26,444	15.22	30
31	Medical Records					31
32	Other Health Care(specify)	2,761	2,895	37,011	12.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,010	225,490	\$ 2,792,443 *	\$ 12.38	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	93	\$ 5,378	1&3	35
36	Medical Director	120	12,000	9&3	36
37	Medical Records Consultant	36	1,992	10&3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	213	8,094	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	80	7,503	12&3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	542	\$ 34,967		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,148	\$ 74,817	10&3	50
51	Licensed Practical Nurses	278	9,864	10&3	51
52	Certified Nurse Assistants/Aides	1,556	33,317	10&3	52
53	TOTAL (lines 50 - 52)	2,982	\$ 117,998		53

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-08

Ending:

11-30-09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IHCA 5,851, CNHA 880
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,488 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,512
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 46,300 Has any meal income been offset against related costs? yes Indicate the amount. \$ 16,211
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 98%
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Michael J. Feriozzi C.P.A.
- (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.

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

The amount, 653,504, is the total of ancillary costs from page 16

Schedule XV, balance sheet, explanation of consolidation column

The consolidation presents Sunny Acres Nursing Home and its investment in Countryside Estates of the County
The financial reporting entity is discussed in the notes to the audited financial statements for Sunny Acres Nursing Home
for the year ended November 30, 2009.

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

interest income	39,897
nursing home's increase in its investment in its wholly owned independent living facility reported using the equity method of accounting	<u>61,180</u>
	<u>101,077</u>

Schedule XIX SUPPORT SCHEDULES G. Schedule of travel and seminar

"In state travel" consists of mileage reimbursements to employees
for attending courses and seminars. Individual reimbursements of \$200 or less.

"Seminar expense" consists of fees and costs of instructional materials for employees attending
courses and seminars. Individual amounts less than \$350.

page 23, XX General information

the independent audit is still in process, audited financial statements will be provided at a later date.
the final audited financial statements will be provided by April 30, 2010.