

Facility Name & ID Number Sunny Hill Nursing Home

0014076 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 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	<u>300</u>	Skilled (SNF)	<u>300</u>	<u>109,500</u>	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	<u>300</u>	TOTALS	<u>300</u>	<u>109,500</u>	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	<u>47,150</u>	<u>12,967</u>	<u>16,663</u>	<u>76,780</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>47,150</u>	<u>12,967</u>	<u>16,663</u>	<u>76,780</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.12%

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 9,453

Medicare Intermediary Wisconsin Physicians Services

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: 11/30/2009

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

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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	704,885	40,038	19,629	764,552		764,552		764,552		1
2	Food Purchase		545,104		545,104		545,104	(6,548)	538,556		2
3	Housekeeping	913,621	87,502		1,001,123		1,001,123		1,001,123		3
4	Laundry	242,742	66,500		309,242		309,242		309,242		4
5	Heat and Other Utilities			231,027	231,027		231,027		231,027		5
6	Maintenance		1,156	158,566	159,722		159,722	705,555	865,277		6
7	Other (specify):*										7
8	TOTAL General Services	1,861,248	740,300	409,222	3,010,770		3,010,770	699,007	3,709,777		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	7,030,844	547,832	308,349	7,887,025		7,887,025	(35,759)	7,851,266		10
10a	Therapy		7,469	928,290	935,759		935,759		935,759		10a
11	Activities	279,313			279,313		279,313		279,313		11
12	Social Services	404,988			404,988		404,988		404,988		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,715,145	555,301	1,242,639	9,513,085		9,513,085	(35,759)	9,477,326		16
	C. General Administration										
17	Administrative	225,420			225,420		225,420		225,420		17
18	Directors Fees										18
19	Professional Services			43,873	43,873		43,873	1,182,477	1,226,350		19
20	Dues, Fees, Subscriptions & Promotions			24,879	24,879		24,879	(4,032)	20,847		20
21	Clerical & General Office Expenses	391,237	52,059	43,949	487,245		487,245	74,681	561,926		21
22	Employee Benefits & Payroll Taxes			4,771,240	4,771,240		4,771,240	628,158	5,399,398		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,796	5,796		5,796		5,796		24
25	Other Admin. Staff Transportation			4,636	4,636		4,636		4,636		25
26	Insurance-Prop.Liab.Malpractice							430,146	430,146		26
27	Other (specify):*										27
28	TOTAL General Administration	616,657	52,059	4,894,373	5,563,089		5,563,089	2,311,430	7,874,519		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,193,050	1,347,660	6,546,234	18,086,944		18,086,944	2,974,678	21,061,622		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			312,523	312,523		312,523	1,367	313,890			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22	22		22	(22)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,235	1,235		1,235		1,235			34
35	Rent-Equipment & Vehicles			48,951	48,951		48,951		48,951			35
36	Other (specify):*											36
37	TOTAL Ownership			362,731	362,731		362,731	1,345	364,076			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		282,688		282,688		282,688		282,688			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			2,882,271	2,882,271		2,882,271		2,882,271			42
43	Other (specify):* Non-allowable cost			9,408	9,408		9,408	(9,408)				43
44	TOTAL Special Cost Centers		282,688	2,891,679	3,174,367		3,174,367	(9,408)	3,164,959			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,193,050	1,630,348	9,800,644	21,624,042		21,624,042	2,966,615	24,590,657			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	(6,548)	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	1,367	30		9
10	Interest and Other Investment Income	(22)	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 PG5A	(70,622)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,825)		\$	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)	3,042,440		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,042,440		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,966,615		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Chamber of Commerce Dues	\$ (389)	20	1
2	Lab Services	(9,408)	43	2
3	Disallow IHCA PAC dues	(3,643)	20	3
4	Reclass R&M per HFS regulations	(21,423)	6	4
5	Disallow non-allowable radiology services	(35,759)	10	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	(70,622)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Will County</u>	<u>100</u>	<u>N/A</u>		<u>Will County</u>	<u>Joliet</u>	<u>Government</u>

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>6 Maintenance</u>	\$	<u>Will County</u>	<u>100.00%</u>	\$ <u>726,978</u>	\$	<u>726,978</u> 1
2	V	<u>19 Professional Services</u>		<u>Will County</u>	<u>100.00%</u>	<u>1,182,477</u>		<u>1,182,477</u> 2
3	V	<u>21 Film Processing</u>		<u>Will County</u>	<u>100.00%</u>	<u>24,914</u>		<u>24,914</u> 3
4	V	<u>21 Telephone</u>		<u>Will County</u>	<u>100.00%</u>	<u>49,767</u>		<u>49,767</u> 4
5	V	<u>22 Employee Benefits</u>		<u>Will County</u>	<u>100.00%</u>	<u>628,158</u>		<u>628,158</u> 5
6	V	<u>26 Insurance</u>		<u>Will County</u>	<u>100.00%</u>	<u>430,146</u>		<u>430,146</u> 6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ <u>3,042,440</u>	\$ *	<u>3,042,440</u> 14

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

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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

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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	\$ 726,978	\$ 1	\$ 726,978	1
2	19	Professional services	Number of warrants	N/A	1	1,182,477	1	1,182,477	2
3	21	Film processing	Estimated time	N/A	1	24,914	1	24,914	3
4	21	Telephone	Direct cost	N/A	1	49,767	1	49,767	4
5	22	Employee Benefits	Direct cost	N/A	1	628,158	1	628,158	5
6	26	Insurance	Direct cost	N/A	1	430,146	1	430,146	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					\$ 3,042,440	\$	\$ 3,042,440	25

SEE ACCOUNTANTS' COMPILATION REPORT

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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							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7	Various		X	Finance Charges								22	7						
8													8						
9	TOTAL Facility Related						\$	\$			\$	22	9						
	B. Non-Facility Related*																		
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$	\$			\$	(22)	14						
15	TOTALS (line 9+line14)						\$	\$			\$		15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	\$ 1,301,314	4
5	150	1976	1976	1,198,083	29,952	40	29,952		1,003,392	5
6										6
7										7
8										8
Improvement Type**										
9	Fencing		1970	727		20			727	9
10	Landscaping		1972	51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance		1973	37,155		10-20			37,155	11
12	Door		1974	38,466		20			38,466	12
13	Asphalt Paving		1975	155,856		15			155,856	13
14	Landscaping		1976	57,254		10-15			57,254	14
15	Sewer and Water		1976	26,031		30			26,031	15
16	Plumbing		1972	183,817		25			183,817	16
17	Heating and Electrical		1972	522,443		20			522,443	17
18	Plumbing		1976	262,534		25			262,534	18
19	Heating and Electrical		1976	508,942		20			508,942	19
20	Sprinkler System and Paving		1975	83,460		25			83,460	20
21	Repairs / Roof		1981	107,858		15			107,858	21
22	Building Improvement		1987	819,813	32,792	25	32,792		737,822	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		142,503	25
26	Washer Repair		1992	3,284		3			3,284	26
27	Site Improvements		1993	101,451		15			101,451	27
28	Laundry Renovation		1994	108,852	3,640	15	3,640		108,852	28
29	Paving Parking Lot		1995	66,260	4,417	15	4,417		64,046	29
30	Laundry, Air Conditioner		1996	362,815		12			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

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Site improvement	1998	\$ 2,936	\$	10	\$	\$	\$ 2,936	37
38	Electrical work	1998	2,085		10			2,085	38
39	Plumbing repair	1998	2,440		10			2,440	39
40	Boiler repair	1998	4,273		10			4,273	40
41	Fence	1999	1,000	50	10	50		1,000	41
42	Air Conditioning Repair	1999	6,284	318	10	318		6,284	42
43	Boiler repair	1999	4,965	244	10	244		4,965	43
44	Doors	1999	4,842	244	10	244		4,842	44
45	Carpeting	1999	1,649	82	10	82		1,649	45
46	Nurses Station	1999	53,554	4,020	10	4,020		53,554	46
47	Wallpaper	2000	840	84	10	84		798	47
48	Vinyl Board	2000	823	82	10	82		779	48
49	Office Compressor	2000	1,205	120	10	120		1,140	49
50	Fire System	2000	3,441	344	10	344		3,268	50
51	Fence	2000	936	94	10	94		893	51
52	Air Ducts	2000	3,090	309	10	309		2,936	52
53	Service Work	2000	1,573	157	10	157		1,492	53
54	Parking Lot	2000	4,860	486	10	486		4,617	54
55	Circular Pumps	2000	1,079	108	10	108		1,026	55
56	Boiler repair	2001	5,326	533	10	533		4,530	56
57									57
58	Plumbing	2002	11,756	1,176	10	1,176		8,820	58
59	Air Cleaner	2002	2,020	202	10	202		1,515	59
60	Boiler	2002	5,658	567	10	567		4,252	60
61	HVAC Control	2002	2,800	280	10	280		2,100	61
62	Fire and Smoke Dampers	2002	26,087	2,609	10	2,609		19,567	62
63	Doors	2002	4,155	416	10	416		3,120	63
64	Fireproof Framing	2002	2,730	273	10	273		2,048	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,504,680	\$ 126,138		\$ 126,138	\$	\$ 6,115,413	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sunny Hill Nursing Home

0014076

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,504,680	\$ 126,138		\$ 126,138	\$	\$ 6,115,413	1
2	HVAC	2003	11,370	1,137	10	1,137		7,391	2
3	Plumbing	2003	11,833	1,183	10	1,183		7,690	3
4	Oven repairs	2003	3,020	302	10	302		1,963	4
5	Dishwasher repairs	2003	1,419	142	10	142		923	5
6	Garbage disposal	2003	2,429	243	10	243		1,579	6
7	Freezer doors	2003	5,610	561	10	561		3,647	7
8	Boiler repairs	2003	21,892	2,189	10	2,189		14,229	8
9	Entrance door repairs	2003	13,240	1,324	10	1,324		8,606	9
10	Washing machine repair	2003	1,045	105	10	105		682	10
11	Site improvement	2003	8,252	825	10	825		5,363	11
12									12
13	Fire alarm system	2004	140,676	14,068	10	14,068		77,374	13
14	Water pipes replaced	2004	44,498	4,450	10	4,450		24,475	14
15	Structural work	2004	5,331	534	10	534		2,937	15
16	Windows	2004	29,590	2,960	10	2,960		16,280	16
17	Wall divider	2004	11,280	1,128	10	1,128		6,204	17
18	Front gate and posts	2004	8,025	802	10	802		4,411	18
19									19
20	Various lighting	2005	60,791	6,080	10	6,080		27,360	20
21	Cabinet	2005	1,200	120	10	120		540	21
22	Cabinet	2005	4,900	490	10	490		2,205	22
23	Pavement	2005	6,581	658	10	658		2,961	23
24	Stump removal and excavation	2005	12,600	1,260	10	1,260		5,670	24
25	Fire alarm modification	2005	4,286	428	10	428		1,926	25
26		2005	23,365	2,336	10	2,336		10,512	26
27	Remove & Replace concrete sidewalk for								27
28	front entrance to facility	2008	7,059	706	10	706		1,059	28
29									29
30	R&M Reclass - Remove & Replace doors	2009	15,489		5	774	774	774	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,960,461	\$ 170,169		\$ 170,943	\$ 774	\$ 6,352,174	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

0014076

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,960,461	\$ 170,169		\$ 170,943	\$ 774	\$ 6,352,174	1
2									2
3	1st Floor F-Wing	2009	3,215,133	40,189	40	40,189		40,189	3
4	- General Conditions								4
5	- Insurance								5
6	- OH&P								6
7	- Demolition, Asbestos removal								7
8	- Asbestos Abatement								8
9	- Materials (Steel)								9
10	- Rough Carpentry								10
11	- Millwork, Casework & Materials								11
12	- Caulking								12
13	- HM Doors & Hardware								13
14	- Glass & Glazing								14
15	- Windows, Installation & Trim								15
16	- Finish Carpentry								16
17	- Floor Cover, Demo, Patch								17
18	- Painting, Wall Coverings, Tape								18
19	- Toilet hardware & Accessories								19
20	- Cubical Curtains								20
21	- Signage								21
22	- Fire Extinguishers								22
23	- Sprinkler System								23
24	- Plumbing Demo								24
25	- Plumbing								25
26	- HVAC								26
27	- Electrical								27
28	- Contingency								28
29	- Contingency								29
30									30
31	Generator	2009	528,400	6,605	40	6,605		6,605	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,703,994	\$ 216,963		\$ 217,737	\$ 774	\$ 6,398,968	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

0014076

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,703,994	\$ 216,963		\$ 217,737	\$ 774	\$ 6,398,968	1
2									2
3	Lower Level E-Wing, Main Entrance & Canopy	2009	3,669,058	45,863	40	45,863		45,863	3
4	- General Conditions								4
5	- Insurance								5
6	- OH&P								6
7	- Demolition, Asbestos removal								7
8	- Asbestos Abatement								8
9	- Rough Carpentry								9
10	- Millwork, Casework & Materials								10
11	- Roofing								11
12	- Caulking								12
13	- HM Doors & Hardware								13
14	- Windows & Glazing								14
15	- Finish Carpentry								15
16	- Floor Coverings								16
17	- Painting, Wall Coverings, Tape								17
18	- Toilet hardware & Accessories								18
19	- Cubical Curtains								19
20	- Signage								20
21	- Fire Extinguishers								21
22	- Sprinkler System								22
23	- Plumbing Demo & Concrete								23
24	- Plumbing								24
25	- HVAC								25
26	- Electrical								26
27	- Contingency								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,373,052	\$ 262,826		\$ 263,600	\$ 774	\$ 6,444,831	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

0014076

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 14,373,052	\$ 262,826		\$ 263,600	\$ 774	\$ 6,444,831	1
2									2
3	1st Floor E-Wing	2009	3,077,955	38,474	40	38,474		38,474	3
4	- General Conditions								4
5	- Insurance								5
6	- OH&P								6
7	- Demolition, Asbestos removal								7
8	- Asbestos Abatement								8
9	- Materials (Steel)								9
10	- Rough Carpentry								10
11	- Millwork, Casework & Materials								11
12	- Caulking								12
13	- HM Doors & Hardware								13
14	- Glass & Glazing								14
15	- Windows, Installation & Trim								15
16	- Finish Carpentry								16
17	- Floor Cover, Demo, Patch								17
18	- Painting, Wall Coverings, Tape								18
19	- Toilet hardware & Accessories								19
20	- Cubical Curtains								20
21	- Signage								21
22	- Fire Extinguishers								22
23	- Sprinkler System								23
24	- Plumbing Demo								24
25	- Plumbing								25
26	- HVAC								26
27	- Electrical								27
28	- Contingency								28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,451,007	\$ 301,300		\$ 302,074	\$ 774	\$ 6,483,305	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

0014076

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	\$ 161,050	\$ 11,223	\$ 11,223	\$	10	\$ 56,532	71
72	Current Year Purchases	5,934		593	593	5	593	72
73	Fully Depreciated Assets	2,003,986					2,003,986	73
74								74
75	TOTALS	\$ 2,170,970	\$ 11,223	\$ 11,816	\$ 593		\$ 2,061,111	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 19,646,977	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 312,523	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,890	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,367	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,544,416	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	N/A		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.

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? YES NO

If NO, see instructions.

	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			1,235			6
7	TOTAL			\$ 1,235			7

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

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: \$ 48,951 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. /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.

Sunny Hill Nursing Home
PROVIDER # 0014076
12/01/08 - 11/30/09

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Helium tanks	\$ 164
Ice Machine	2,800
Other Medical Equipment	711
Dietary Equipment	4,325
Mattress	40,303
Oxygen Tanks	648
	<u>48,951</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(2,3)	hrs	\$	7,093	\$ 531,965	\$ 4,305	7,093	\$ 536,270	1
2	Licensed Speech and Language Development Therapist	10A(2,3)	hrs		596	44,684	362	596	45,046	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		4,615	346,136	2,802	4,615	348,938	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				282,688		282,688	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			\$	12,304	\$ 922,785	\$ 290,157	12,304	\$ 1,212,942	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home# 0014076Report Period Beginning: 12/01/08

Ending:

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	10,991,370	11,006,859	15
16	Equipment, at Historical Cost	2,165,036	2,170,970	16
17	Accumulated Depreciation (book methods)	(8,543,049)	(8,544,416)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,082,505	\$ 11,102,561	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,082,505	\$ 11,102,561	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,133,657	1,133,657	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)	\$ 1,133,657	\$ 1,133,657	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)	\$ 1,133,657	\$ 1,133,657	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,948,848	\$ 9,968,904	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,082,505	\$ 11,102,561	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,335,069	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,335,069	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,119,865)	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)	\$ (4,119,865)	17
	B. Transfers (Itemize):		
18	Interfund Transfers	6,733,644	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 6,733,644	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,948,848	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home# 0014076Report 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	\$ 15,118,346	1
2	Discounts and Allowances for all Levels	901,902	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,020,248	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,160,713	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,160,713	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,548	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,710	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,443	19
20	Radiology and X-Ray	25,182	20
21	Other Medical Services	150	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 323,033	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Sundries</u>	183	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 183	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,504,177	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,010,770	31
32	Health Care	9,513,085	32
33	General Administration	5,563,089	33
B. Capital Expense			
34	Ownership	362,731	34
C. Ancillary Expense			
35	Special Cost Centers	292,096	35
36	Provider Participation Fee	2,882,271	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,624,042	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,119,865)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,119,865)	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.
Government Entity. Part of County.

*** 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

0014076

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	2,049	2,174	\$ 86,528	\$ 39.80	1
2	Assistant Director of Nursing	2,124	2,338	75,920	32.47	2
3	Registered Nurses	35,207	40,818	1,197,802	29.34	3
4	Licensed Practical Nurses	85,402	95,731	2,245,184	23.45	4
5	CNAs & Orderlies	195,826	219,288	3,148,583	14.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,647	15,167	276,827	18.25	8
9	Activity Director					9
10	Activity Assistants	15,059	16,545	279,313	16.88	10
11	Social Service Workers	14,800	15,547	404,988	26.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	45,527	48,059	704,885	14.67	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	59,624	68,654	913,621	13.31	18
19	Laundry	15,841	18,241	242,742	13.31	19
20	Administrator	1,984	2,039	90,470	44.37	20
21	Assistant Administrator	2,476	2,617	83,097	31.75	21
22	Other Administrative	1,824	2,131	51,853	24.33	22
23	Office Manager					23
24	Clerical	17,702	19,681	391,237	19.88	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)	509,092	569,030	\$ 10,193,050 *	\$ 17.91	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	Monthly	\$ 19,629	1(3) 35
36	Medical Director	Monthly	6,000	9(3) 36
37	Medical Records Consultant	Monthly	1,800	10(3) 37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	9,466	10(3) 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	Monthly	5,505	10A(3) 43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)		\$ 42,400	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	632	\$ 26,342	10(3) 50
51	Licensed Practical Nurses	2,623	104,157	10(3) 51
52	Certified Nurse Assistants/Aides	5,659	130,257	10(3) 52
53	TOTAL (lines 50 - 52)	8,914	\$ 260,756	53

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Nursing Home

Provider #: 0014076
12/1/2008 to 11/30/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Subtotal	43,873
Total (agree to Schedule V, line 19, column 3)	<u>43,873</u>
Allocated from Will County	1,182,477
Total (agree to Schedule V, line 19, column 8)	<u><u>1,226,350</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Nursing Home

0014076

Report Period Beginning: 12/01/08

Ending: 11/30/09

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. - \$2,140
- (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? 5 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 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. \$ 2,882,271
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,548
- (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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT