

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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 _____

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,104	12,956	4,297	31,357	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,104	12,956	4,297	31,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.05%

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)
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 4,290

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: n/a Fiscal Year: 11/30/2013

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

Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

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	286,626	17,644	6,490	310,760		310,760		310,760		1
2	Food Purchase		255,883		255,883	(40,000)	215,883	(20,361)	195,522		2
3	Housekeeping	194,053	32,034		226,087		226,087		226,087		3
4	Laundry	40,181	7,870		48,051		48,051		48,051		4
5	Heat and Other Utilities			142,858	142,858		142,858	(3,553)	139,305		5
6	Maintenance	75,279	61,849	2,400	139,528		139,528		139,528		6
7	Other (specify):*										7
8	TOTAL General Services	596,139	375,280	151,748	1,123,167	(40,000)	1,083,167	(23,914)	1,059,253		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,927,199	155,600	2,178	2,084,977		2,084,977	(53,843)	2,031,134		10
10a	Therapy	30,722	131,306	856,018	1,018,046	(987,342)	30,704		30,704		10a
11	Activities	96,164	8,022		104,186		104,186		104,186		11
12	Social Services	16,054	4,000	4,125	24,179		24,179		24,179		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,070,139	298,928	874,321	3,243,388	(987,342)	2,256,046	(53,843)	2,202,203		16
	C. General Administration										
17	Administrative	142,402	7,000	67,450	216,852		216,852	1,560	218,412		17
18	Directors Fees										18
19	Professional Services			74,011	74,011		74,011	(360)	73,651		19
20	Dues, Fees, Subscriptions & Promotions			34,440	34,440		34,440	(29,224)	5,216		20
21	Clerical & General Office Expenses	76,016	12,446		88,462		88,462	(19)	88,443		21
22	Employee Benefits & Payroll Taxes			735,320	735,320	40,000	775,320		775,320		22
23	Inservice Training & Education			5,785	5,785		5,785		5,785		23
24	Travel and Seminar			3,691	3,691		3,691		3,691		24
25	Other Admin. Staff Transportation		2,344		2,344		2,344		2,344		25
26	Insurance-Prop.Liab.Malpractice			78,030	78,030		78,030		78,030		26
27	Other (specify):*										27
28	TOTAL General Administration	218,418	21,790	998,727	1,238,935	40,000	1,278,935	(28,043)	1,250,892		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,884,696	695,998	2,024,796	5,605,490	(987,342)	4,618,148	(105,800)	4,512,348		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 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			187,943	187,943		187,943		187,943			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):*			250,000	250,000		250,000	(250,000)				36
37	TOTAL Ownership			437,943	437,943		437,943	(250,000)	187,943			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					987,342	987,342		987,342			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,564	1,564		1,564	(1,564)				41
42	Provider Participation Fee			59,228	59,228		59,228		59,228			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		60,792		60,792	987,342	1,048,134	(1,564)	1,046,570			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,884,696	756,790	2,462,739	6,104,225		6,104,225	(357,364)	5,746,861			45

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

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	(20,361)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,553)	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	1,560	17		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	(360)	19		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	(250,000)	36		24
25	Fund Raising, Advertising and Promotional	(4,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(24,739)	20		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (301,938)		\$	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))	\$ (301,938)		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			856,018	10a	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology			23,194	10a	42
43	Prescription Drugs			108,112	10a	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 987,324		47

BHF USE ONLY						
48		49		50		51
						52

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	cost recovery of medical supplies sold to residents	\$ (53,843)	10	1
2				2
3	coffee and gift shop	(1,564)	41	3
4				4
5	uniform costs recovered	(19)	21	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		(55,426)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

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	(20,361)	0	0	0	0	0	0	0	0	0	0	(20,361)	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	(3,553)	0	0	0	0	0	0	0	0	0	0	(3,553)	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	(23,914)	0	(23,914)	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	(53,843)	0	0	0	0	0	0	0	0	0	0	(53,843)	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	(53,843)	0	(53,843)	16									
	C. General Administration													
17	Administrative	1,560	0	0	0	0	0	0	0	0	0	0	1,560	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(360)	0	0	0	0	0	0	0	0	0	0	(360)	19
20	Fees, Subscriptions & Promotions	(29,224)	0	0	0	0	0	0	0	0	0	0	(29,224)	20
21	Clerical & General Office Expenses	(19)	0	0	0	0	0	0	0	0	0	0	(19)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,043)	0	(28,043)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,800)	0	(105,800)	29									

STATE OF ILLINOIS

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12/01/2012 Ending:

Summary B

11/30/2013

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):*	(250,000)	0	0	0	0	0	0	0	0	0	0	(250,000)	36
37	TOTAL Ownership	(250,000)	0	0	0	0	0	0	0	0	0	0	(250,000)	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	(1,564)	0	0	0	0	0	0	0	0	0	0	(1,564)	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	(1,564)	0	0	0	0	0	0	0	0	0	0	(1,564)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(357,364)	0	0	0	0	0	0	0	0	0	0	(357,364)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	Petersburg, Illinois	independent
				Of the County		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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item							
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:

12/01/2012

Ending:

11/30/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	menard county	100%	none		none			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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning: 12/01/2012

Ending: 1/30/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
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. \$ _____ Line # _____

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Acres Nursing Home COUNTY Menard

FACILITY IDPH LICENSE NUMBER 0005009

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

Countryside Estates of the County is an independent living facility located adjacent to Sunny Acres Nursing Home. The financial operations of Countryside Estates of the County are accounted for in a separate and distinct Menard County fund, as are the financial operations of Sunny Acres Nursing Home. Menard County issued revenue bonds in April, 1998 through the Sunny Acres Nursing Home Fund to partially finance the construction of the facility for the operation of Countryside Estates of the County. That portion of the facility'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 nursing home</u>			\$ <u>25,000</u>	1
2	<u>and independent living facility are situated on</u>				2
3	TOTALS			\$ <u>25,000</u>	3

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2012 Ending:

11/30/2013

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	40	\$	\$	\$ 526,787	4
5	38		1977	1977	568,714	14,218	40	14,218		511,847	5
6			1984	1984	61,842	2,061	30	2,061		60,804	6
7	10		1993	1993	654,160	16,354	40	16,354		329,806	7
8			1995	1995	68,999	3,450	20	3,450		62,100	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	17,565	5-30	17,565		124,876	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		7-10			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	4,119	10-15	4,119		61,235	31
32		seal parking lot, fences improvements		2003	16,153	663	5-10	663		16,183	32
33		flooring, alarm systems, office remodelling		2004	67,361	5,532	10-20	5,532		52,625	33
34		kitchen tile and ceiling, carpeting, drapes, circuit improvements		2005	17,158	1,715	10	1,715		14,578	34
35		entrance improvements, wiring cable system, front doors		2006	45,926	4,226	10-20	4,226		36,435	35
36		carpeting, vinyl flooring for resident rooms		2007	13,077	1,868	7	1,868		12,142	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2012 Ending: 11/30/2013

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	\$ 2,695	37
38	front walk and handrails	2007	19,000	950	20	950		6,099	38
39	hot water heater	2007	3,823	546	7	546		3,413	39
40	foam roofing system	2007	141,519	7,076	20	7,076		44,225	40
41	draft inducer and heater	2007	4,577	654	7	654		4,414	41
42	lockinvar water heater	2007	5,292	(759)	7	(759)		4,530	42
43	extend sprinkler system	2008	169,566	8,478	20	8,478		45,216	43
44	replace boiler and cooling system	2009	388,232	25,882	15	25,882		118,626	44
45	alarm system for building	2009	30,000	2,000	15	2,000		8,333	45
46	bath entry	2009	5,460	546	10	546		2,412	46
47	back flow preventer	2009	3,602	515	7	515		2,146	47
48	vinyl flooring for resident rooms	2009	3,406	681	5	681		3,008	48
49	frame up pictures	2009	3,842	768	5	768		3,712	49
50	air unit compressor	2009	4,447	889	5	889		3,852	50
51	office improvements carpet, walls	2010	4,491	50	15	50		200	51
52	vinyl floor replacement for resident rooms	2011	9,594	1,919	5	1,919		4,797	52
53	window replacement	2011	128,150	6,408	20	6,408		13,398	53
54	soffets and facia replacement	2011	39,732	1,986	20	1,986		3,972	54
55	window replacement	2012	1,263		20			63	55
56	100 gallon hot water heater replacement	2012	9,100	217	7	217		434	56
57	vinyl floor covering for resident rooms	2012	11,552	1,155	5	1,155		2,311	57
58	emergency generator replacement	2013	225,525		20				58
59	sewer waste line improvement	2013	12,980	216	10	216		216	59
60	vinyl floor covering for resident rooms	2013	5,642	188	5	188		188	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)		\$ 4,235,131	\$ 132,545		\$ 132,545	\$	\$ 2,824,387	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 476,125	\$ 49,963	\$ 49,963	\$		\$ 289,173	71
72	Current Year Purchases	31,278	4,062	4,062		3-5	4,062	72
73	Fully Depreciated Assets	780,196	353	353		5-20	780,196	73
74								74
75	TOTALS	\$ 1,287,599	\$ 54,378	\$ 54,378	\$		\$ 1,073,431	75

D. Vehicle Costs. (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					44,625	77
78	facility operations	pickup truck	2006	6,120	1,020	1,020			6,120	78
79										79
80	TOTALS			\$ 73,065	\$ 1,020	\$ 1,020	\$		\$ 73,065	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)	\$ 5,620,795	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,943	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 187,943	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)	\$ 3,970,883	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: not applicable

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				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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		\$	\$	21

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

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12/01/2012 Ending: 11/30/2013
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. 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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 348,259	\$ 52,239		\$ 400,498	1
2	Licensed Speech and Language Development Therapist		hrs				153,060	22,959		176,019	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				354,699	56,108		410,807	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								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			\$			\$ 856,018	\$ 131,306		\$ 987,324	14

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/01/2012

Ending:

11/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2013

(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	\$ 2,908,063	\$ 3,554,881	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 516,626)	1,233,955	1,232,200	3
4	Supply Inventory (priced at FIFO)	18,000	21,517	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,355	12,355	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,172,373	\$ 4,820,953	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,739,487		12
13	Land			13
14	Buildings, at Historical Cost	4,235,131	6,632,782	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,360,664	1,465,256	16
17	Accumulated Depreciation (book methods)	(3,970,883)	(5,364,090)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	323,636	323,636	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,688,035	\$ 3,057,584	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,860,408	\$ 7,878,537	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 401,553	\$ 414,424	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	117,758	123,016	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	227,328	227,328	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)	\$ 746,639	\$ 764,768	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)	\$ 746,639	\$ 764,768	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,113,769	\$ 7,113,769	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,860,408	\$ 7,878,537	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,165,132	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,165,132	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	8,637	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)	\$ 8,637	17
B. Transfers (Itemize):			
18	return of capital to Menard County's 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)	\$ 7,113,769	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,970,455	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,970,455	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	3,421	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	20,361	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	53,843	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)	\$ 77,625	23
D. Non-Operating Revenue			
24	Contributions	10,483	24
25	Interest and Other Investment Income***	54,299	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,782	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)	\$ 6,112,862	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,123,167	31
32	Health Care	3,243,388	32
33	General Administration	1,238,935	33
B. Capital Expense			
34	Ownership	437,943	34
C. Ancillary Expense			
35	Special Cost Centers	1,564	35
36	Provider Participation Fee	59,228	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,104,225	40
41	Income before Income Taxes (line 30 minus line 40)**	8,637	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 8,637	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,591,715	44
45	Private Pay - Net Inpatient Revenue	1,996,580	45
46	Medicare - Net Inpatient Revenue	2,382,160	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,970,455	49

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

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

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

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	1,617	2,132	\$ 68,476	\$ 32.12	1
2	Assistant Director of Nursing	2,074	2,290	74,208	32.41	2
3	Registered Nurses	3,547	4,069	85,629	21.04	3
4	Licensed Practical Nurses	28,164	30,152	593,991	19.70	4
5	CNAs & Orderlies	78,012	83,905	960,627	11.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,087	36,857	17.66	9
10	Activity Assistants	4,775	5,159	59,307	11.50	10
11	Social Service Workers	1,420	1,540	16,054	10.42	11
12	Dietician					12
13	Food Service Supervisor	2,065	2,074	30,164	14.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,069	6,774	82,152	12.13	15
16	Dishwashers	18,234	19,377	174,310	9.00	16
17	Maintenance Workers	5,451	6,260	75,279	12.03	17
18	Housekeepers	18,099	19,360	194,053	10.02	18
19	Laundry	4,144	4,504	40,181	8.92	19
20	Administrator	1,631	1,876	74,960	39.96	20
21	Assistant Administrator					21
22	Other Administrative	5,427	5,997	67,442	11.25	22
23	Office Manager	1,724	2,000	45,241	22.62	23
24	Clerical	1,716	1,973	30,775	15.60	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)	1,690	1,832	30,722	16.77	30
31	Medical Records					31
32	Other Health Care(specify)	7,046	7,529	144,268	19.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,811	210,890	\$ 2,884,696 *	\$ 13.68	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	94	\$ 6,490	1&3	35
36	Medical Director	120	12,000	9&3	36
37	Medical Records Consultant	35	1,880	10&3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	298	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	50	4,125	12&3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	307	\$ 24,793		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Patricia Mcneal	administrator	none	\$ 74,960	Workers' Compensation Insurance	\$ 142,738	IDPH License Fee	\$ 2,715	
various personnel (5)	administrative support	none	67,442	Unemployment Compensation Insurance	2,210	Advertising: Employee Recruitment	29,223	
				FICA Taxes	215,420	Health Care Worker Background Check	2,501	
				Employee Health Insurance	118,923	(Indicate # of checks performed <u>36</u>)		
				Employee Meals	40,000	Patient Background Checks	102	
				Illinois Municipal Retirement Fund (IMRF)*	256,029			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 142,402					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 775,320	
Description			Amount			Less: Public Relations Expense		(4,485)
information technology including MDI Achieve			\$ 39,671			Non-allowable advertising		(22,994)
employees recognition and awards			7,101			Yellow page advertising		(1,744)
employees physicals and check ups			14,454			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,216
dues and memberships			6,224					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 67,450					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Michael J. Feriozzi C.P.A.	audit and accounting		\$ 23,350				Out-of-State Travel	\$
Revere Healthcare LTD	financial consulting		45,976				In-State Travel	3,691
Administrative Services	cafeteria plan administration		3,685				Seminar Expense	
F R & R	resident consulting		1,000				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 74,011	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,691

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

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; INHAA 100
- (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. \$ 32,366 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. \$ 59,228
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. \$ 40,000 Has any meal income been offset against related costs? yes Indicate the amount. \$ 20,361
- (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? 90%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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, 987,342, 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, 2013.

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

interest income	19,761
nursing home's increase in its investment in its wholly owned independent living facility reported using the equity method of accounting	<u>39,777</u>
	<u><u>59,538</u></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 \$150 or less.

Schedule V, Cost center Expenses, line 36, other

This amount, 250,000, is the current year's increase in the allowance for doubtful accounts (bad debts),
the amount has been adjusted out of this cost report in arriving at adjusted total costs evidenced in the column 8 data.

page 23, XX General information

the independent audit is still in process, audited financial statements will be provided at a later date.
expected to be no later than by April 30, 2014.