

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	17,428	10,873	2,411	30,712	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,428	10,873	2,411	30,712	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.38%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 prison 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 12/1/1966

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 2,411

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	222,502	20,294		242,796		242,796		242,796		1
2	Food Purchase		189,049		189,049		189,049		189,049		2
3	Housekeeping	173,639	37,570		211,209		211,209		211,209		3
4	Laundry	52,689	12,656		65,345		65,345		65,345		4
5	Heat and Other Utilities			161,016	161,016		161,016		161,016		5
6	Maintenance	103,260	87,890	89,951	281,101		281,101		281,101		6
7	Other (specify):*										7
8	TOTAL General Services	552,090	347,459	250,967	1,150,516		1,150,516		1,150,516		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,849,380	138,347	211,619	2,199,346	155,462	2,354,808		2,354,808		10
10a	Therapy		220,675	39,877	260,552	(260,468)	84		84		10a
11	Activities	68,241	8,063		76,304		76,304		76,304		11
12	Social Services	49,978		5,300	55,278		55,278		55,278		12
13	CNA Training	5,731	1,072		6,803		6,803		6,803		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,973,330	368,157	268,796	2,610,283	(105,006)	2,505,277		2,505,277		16
	C. General Administration										
17	Administrative	76,885			76,885		76,885		76,885		17
18	Directors Fees										18
19	Professional Services			349,579	349,579		349,579	(6,191)	343,388		19
20	Dues, Fees, Subscriptions & Promotions			256,697	256,697	(227,770)	28,927	(16,461)	12,466		20
21	Clerical & General Office Expenses	265,841	27,498	9,910	303,249	(155,462)	147,787		147,787		21
22	Employee Benefits & Payroll Taxes			705,559	705,559		705,559		705,559		22
23	Inservice Training & Education			2,708	2,708		2,708		2,708		23
24	Travel and Seminar			11,332	11,332		11,332	(6,333)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			73,796	73,796		73,796		73,796		26
27	Other (specify):* Lost Resident Items			48,085	48,085		48,085	(48,000)	85		27
28	TOTAL General Administration	342,726	27,498	1,457,666	1,827,890	(383,232)	1,444,658	(76,985)	1,367,673		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,868,146	743,114	1,977,429	5,588,689	(488,238)	5,100,451	(76,985)	5,023,466		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			164,922	164,922		164,922	(1,344)	163,578			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			9,211	9,211		9,211		9,211			35
36	Other (specify):*											36
37	TOTAL Ownership			174,133	174,133		174,133	(1,344)	172,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			976,707	976,707	260,468	1,237,175		1,237,175			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					227,770	227,770		227,770			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			976,707	976,707	488,238	1,464,945		1,464,945			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,868,146	743,114	3,128,269	6,739,529		6,739,529	(78,329)	6,661,200			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:

12/1/2017

Ending:

11/30/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
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	(1,344)			9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(42)			17
18	Fines and Penalties				18
19	Entertainment	(6,333)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,191)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)			24
25	Fund Raising, Advertising and Promotional	(16,419)			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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,329)		\$	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))	\$ (78,329)		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						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
							52

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12/1/2017

Ending: 11/30/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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		(6,191)	19	22
23		(42)	20	23
24		(48,000)	27	24
25		(16,419)	20	25
26		(1,344)	30	26
27		(6,333)	24	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	(78,329)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12/1/2017

Ending:

11/30/2018

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	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	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,191)	0	0	0	0	0	0	0	0	0	0	(6,191)	19
20	Fees, Subscriptions & Promotions	(16,461)	0	0	0	0	0	0	0	0	0	0	(16,461)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,333)	0	0	0	0	0	0	0	0	0	0	(6,333)	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):*	(48,000)	0	0	0	0	0	0	0	0	0	0	(48,000)	27
28	TOTAL General Administration	(76,985)	0	0	0	0	0	0	0	0	0	0	(76,985)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(76,985)	0	0	0	0	0	0	0	0	0	0	(76,985)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/1/2017 Ending:

11/30/2018

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	(1,344)	0	0	0	0	0	0	0	0	0	0	(1,344) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,344)	0	0	0	0	0	0	0	0	0	0	(1,344) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,329)	0	0	0	0	0	0	0	0	0	0	(78,329) 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					
List of Board Commissioners and Nursing Home Advisory Committee Attached						

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

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

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

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

Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/1/2017

Ending:

11/30/2018

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	Board Members are not compensated								\$		1
2	for their services										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: 12/1/2017

Ending: 1/30/2018

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

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

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

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:

12/1/2017

Ending:

11/30/2018

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	7	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										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10	Interest Income									10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related									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. \$ None Line # _____

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

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

2017 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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Land is owned by Menard County. There is no lease.</u>			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/1/2017

Ending:

11/30/2018

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	106		1966	1966	\$ 526,787	\$	40	\$	\$	\$	4
5			1977	1977	568,714		40				5
6			1984	1984	61,842		30				6
7			1993	1993	654,160	16,354	40	16,354			7
8			1995	1995	68,999		20				8
	Improvement Type**										
9		generator		1980	28,901						9
10		fire alarm system		1981	9,805						10
11		none		1982							11
12		gazebo and floor coverings		1983	12,750						12
13		flooring, phone, and paging systems, air conditioner		1984	30,885						13
14		sun room, remodelling, wall paper		1985	7,061						14
15		kitchen remodelling, wallpaper, parking lot, nightlight, etc		1986	36,333						15
16		boiler repair, sprinkler system, office remodelling		1987	17,193						16
17		roof, chimney, carpeting, sprinkler system		1988	147,826						17
18		compressor, canopy, carport		1989	6,472						18
19		asbestos removal, flooring, water heater, landscaping, canopy		1990	28,642						19
20		main air conditioning unit		1991	5,194						20
21		none		1992							21
22		new lagoon, tiling, hot wate heater, aviary		1993	223,851						22
23		fill old lagoon, flooring, wallpaper, and signs		1994	49,671						23
24		major boiler repair, air conditioners, ceiling tile replacement		1995	10,685						24
25		special needs unit, resident walking gardens, vinyl soffets		1996	139,517						25
26		donor recognition,wall, remodelling, draperies, and shades		1997	20,798						26
27		major boiler repair, air conditioners, ceiling tile replacement		1998	21,699						27
28		two commercial water hearters, entrybath, rooftop		1999	41,844						28
29		plumbing, improvements, stuctural improvements		2000	18,896						29
30		plumbing, electrical, boiler rehabilitation		2001	22,162						30
31		structural improvements, sewer lines and walls		2002	77,586						31
32		seal parking lot, fences improvements		2003	16,153						32
33		flooring, alarm systems, office remodelling		2004	67,361	1,204		1,204			33
34		kitchen tile and ceiling, carpeting, drapes, circuit improvements		2005	17,158						34
35		entrance improvements, wiring cable system, front doors		2006	45,926						35
36		carpeting, vinyl flooring for resident rooms		2007	13,077						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:

12/1/2017 Ending:

11/30/2018

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		\$ 409			37
38	front walk and handrails	2007	19,000	950		950			38
39	hot water heater	2007	3,823						39
40	foam roofing system	2007	141,519	7,076		7,076			40
41	draft inducer and heater	2007	4,577						41
42	lockinvar water heater	2007	5,292						42
43	extend sprinkler system	2008	163,627	8,478		8,181	(297)		43
44	replace boiler and cooling system	2009	387,410	25,882		25,882			44
45	alarm system for building	2009	30,000	2,000		2,000			45
46	bath entry	2009	3,406	120		120			46
47	back flow preventer	2009	3,602						47
48									48
49									49
50	air unit compressor	2009	4,447						50
51	office improvements	2010		50			(50)		51
52	vinyl floor replacement for resident rooms	2011	9,594						52
53	window replacement	2011	121,198	6,408		6,471	63		53
54	soffets and facia replacement	2011	39,732	1,986		1,986			54
55	window replacement	2012		63			(63)		55
56	100 gallon hot water heater replacement	2012	9,100	1,300		217	(1,083)		56
57	vinyl floor covering for resident rooms	2012	5,205			521	521		57
58	emergency generator replacement	2013	222,148	11,276		11,107	(169)		58
59	sewer waste line improvement	2013	12,980	1,298		1,298			59
60	vinyl floor covering for resident rooms	2013	5,642	1,128		1,128			60
61	resident rooms and office painting	2014	41,690	4,169		4,169			61
62	flooring for resident rooms	2014	13,141	2,628		2,628			62
63	magnetic holders and compressor and fans etc	2014	7,204	986		720	(266)		63
64	hard wiring for new IT system	2015	8,935	596		596			64
65									65
66	roof replacement	2015	283,332	18,889		18,889			66
67	resident room flooring	2015	14,695	2,939		2,939			67
68	modification of waste and vent piping system - Lily wing	2015	60,369	4,025		4,025			68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,625,744	\$ 120,214		\$ 118,870	\$ (1,344)	\$	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,625,744	\$ 120,214		\$ 118,870	\$ (1,344)		1
2	Revamp sewer system	2016	18,185	1,819	10	1,819			2
3	Door replacement	2016	2,842	284	10	284			3
4									4
5	Replace water heater	2017	6,816	325	7	325			5
6	Septic Tank replacement	2017	5,419	258	7	258			6
7									7
8	Water heater replacements (2)	2018	17,590	1,257	7	1,257			8
9	Ceiling replacement - admin wing	2018	13,476	562	10	562			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	TOTAL (lines 1 thru 33)		\$ 4,690,072	\$ 124,719		\$ 123,375	\$ (1,344)		34

**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	\$ 367,344	\$ 40,203	\$ 40,203	\$		\$	71
72	Current Year Purchases	9,960						72
73	Fully Depreciated Assets	1,025,591						73
74								74
75	TOTALS	\$ 1,402,895	\$ 40,203	\$ 40,203	\$		\$	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	\$	\$	\$		\$	76
77	facility operations	2006 ford supreme van	2006	44,625						77
78	facility operations	pickup truck	2006	6,120						78
79										79
80	TOTALS			\$ 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)	\$ 6,166,032	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 164,922	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 163,578	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,344)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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: None

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 9,211 Description: Televisions and copiers

(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.

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 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)		5,731		5,731
4	Clinical Wages (b)		1,072		1,072
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,803	\$	\$ 6,803
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,803		

- (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.

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	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
DROP-OUTS	
1. From this facility	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
TOTAL TRAINED	<input style="width: 100px;" type="text"/>

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 413,526	\$		\$ 413,526	1
2	Licensed Speech and Language Development Therapist		hrs			157,272			157,272	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			405,909	84		405,993	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				220,591		220,591	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					39,877			39,877	13
14	TOTAL			\$		\$ 1,016,584	\$ 220,675		\$ 1,237,259	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: 12/1/2017

Ending: 11/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2018

(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	\$ 4,292,223	\$	1
2	Cash-Patient Deposits	21,122		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	852,283		3
4	Supply Inventory (priced at FIFO)	12,311		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,712		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	245,856		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,429,507	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,768,976		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,475,959		16
17	Accumulated Depreciation (book methods)	(4,932,202)		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): <u>Deferred Pension</u>	686,381		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,999,114	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,428,621	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,036,651	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,122		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	218,870		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,577		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	<u>Bed Tax</u>	22,522		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,338,742	\$	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	<u>Net Pension Liability</u>	368,863		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 368,863	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,707,605	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,721,016	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,428,621	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,007,063	1
2	Restatements (describe):		2
3	2017 Audit Adjustment - Pension Liability	(394,831)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,612,232	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	165,477	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)	\$ 165,477	17
B. Transfers (Itemize):			
18	To Menard County	(56,693)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (56,693)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,721,016	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	\$ 6,018,484	1
2	Discounts and Allowances for all Levels	(2,657,151)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,361,333	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,119,195	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,119,195	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	385,671	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,716	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 388,387	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	36,091	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,091	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)	\$ 6,905,006	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,150,516	31
32	Health Care	2,610,283	32
33	General Administration	1,827,890	33
B. Capital Expense			
34	Ownership	174,133	34
C. Ancillary Expense			
35	Special Cost Centers	976,707	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,739,529	40
41	Income before Income Taxes (line 30 minus line 40)**	165,477	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 165,477	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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: 12/1/2017

Ending:

11/30/2018

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	1,931	2,054	\$ 81,279	\$ 39.57	1
2	Assistant Director of Nursing	1,989	2,116	67,885	32.08	2
3	Registered Nurses	7,198	7,657	240,988	31.47	3
4	Licensed Practical Nurses	22,516	23,953	595,002	24.84	4
5	CNAs & Orderlies	56,638	60,253	864,226	14.34	5
6	CNA Trainees	626	666	5,731	8.61	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,962	5,279	68,241	12.93	10
11	Social Service Workers	2,250	2,394	49,978	20.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,153	20,376	222,502	10.92	15
16	Dishwashers					16
17	Maintenance Workers	5,720	6,085	103,260	16.97	17
18	Housekeepers	15,456	16,443	173,639	10.56	18
19	Laundry	5,597	5,954	52,689	8.85	19
20	Administrator	1,955	2,080	76,885	36.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,933	12,695	265,841	20.94	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)	157,924	168,005	\$ 2,868,146 *	\$ 17.07	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	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,319		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,544		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	5,300		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,163		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 54,051		50
51	Licensed Practical Nurses	98,311		51
52	Certified Nurse Assistants/Aides	52,150		52
53	TOTAL (lines 50 - 52)	\$ 204,512		53

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	
Sarah Yoder	Administrator		\$ 76,885	Workers' Compensation Insurance	\$ 90,905	IDPH License Fee	\$	
				Unemployment Compensation Insurance	(6,277)	Advertising: Employee Recruitment	7,634	
				FICA Taxes	219,413	Health Care Worker Background Check (Indicate # of checks performed)	2,383	
				Employee Health Insurance	209,268	Patient Background Checks		
				Employee Meals		PR	2,286	
				Illinois Municipal Retirement Fund (IMRF)*	180,454	Dues & Subscriptions	830	
				Other Benefits	11,796	License & Fees	2,037	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,885			Less: Public Relations Expense	(2,286)	
B. Administrative - Other						Non-allowable advertising	(418)	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,466	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 705,559			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$		
Heritage Operations Group	Management		\$ 315,308				Out-of-State Travel	\$
Michael J Feriozzi CPA	Audit & Accounting		28,080					
							In-State Travel	
								10,239
								0
							Seminar Expense	1,093
								(6,333)
Legal adj to Zero			6,191				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 349,579	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/1/2017

Ending: 11/30/2018

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? No
If YES, give association name and amount. _____
- (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? 7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 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. \$ 227,770
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 16,737
- (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? 100%
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? Yes
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Michael J Feriozzi CPA
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

**Sunny Acres Home of Menard County
2018 Cost Report
Supplemental Schedules
Reclassification Entries**

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 220,591
Purchased Hospital Services	32,668
Purchased Laboratory Services	7,134
Purchased Radiology Services	75
Amount Reclassified to Line 39	<u>\$ 260,468</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (58,035)
Provider Assesment Fee - \$6.07	<u>(169,735)</u>
	<u>(227,770)</u>
Provider Participation Fee	<u>227,770</u>

3. Schedule V - Line 21 to Line 10 - Reclassification

<u>Line Item</u>	
MDS Coordinators/Care Planners - Line 21, Col 1	\$ (119,968)
Medical Records Specialists - Line 21, Col 1	<u>(35,494)</u>
	<u>(155,462)</u>
Nursing & Medical Records Line 10	<u>155,462</u>