FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0014076

Facility Name: Sunny Hill Nrsg H of Will Co

Address: 421 Doris Avenue (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-8710 **Fax #** (815) 727-8637

HFS ID Number:

Date of Initial License for Current Owners: 1955

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/12 to 11/30/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	280	Skilled (SNF)	280	102,200	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	280	TOTALS	280	102,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	44,770	14,153	10,689	69,612	8
9	SNF/PED					9
10	ICF	1,653	102		1,755	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,423	14,255	10,689	71,367	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.83%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 280 and days of care provided 4,232

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/13 Fiscal Year: 11/30/13

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	849,914	41,425	62,362	953,701		953,701		953,701			1
2	Food Purchase		575,650		575,650		575,650	(3,134)	572,516			2
3	Housekeeping	751,354	108,015		859,369		859,369		859,369			3
4	Laundry	197,264	31,181	17,611	246,056		246,056		246,056			4
5	Heat and Other Utilities			248,110	248,110		248,110		248,110			5
6	Maintenance			158,063	158,063		158,063	750,320	908,383			6
7	Other (specify):*											7
8	TOTAL General Services	1,798,532	756,271	486,146	3,040,949		3,040,949	747,186	3,788,135			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	6,599,277	537,993	664,865	7,802,135		7,802,135	(15,439)	7,786,696			10
10a	Therapy	144,182			144,182		144,182		144,182			10a
11	Activities	233,972			233,972		233,972		233,972			11
12	Social Services	326,233			326,233		326,233		326,233			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,303,664	537,993	670,865	8,512,522		8,512,522	(15,439)	8,497,083			16
	C. General Administration											
17	Administrative	218,225			218,225		218,225		218,225			17
18	Directors Fees											18
19	Professional Services			95,152	95,152		95,152	984,134	1,079,286			19
20	Dues, Fees, Subscriptions & Promotions			74,058	74,058		74,058	(23,160)	50,898			20
21	Clerical & General Office Expenses	356,349	74,145	31,421	461,915		461,915	58,036	519,951			21
22	Employee Benefits & Payroll Taxes			5,500,791	5,500,791		5,500,791	556,941	6,057,732			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,523	2,523		2,523		2,523			24
25	Other Admin. Staff Transportation			1,115	1,115		1,115		1,115			25
26	Insurance-Prop.Liab.Malpractice							309,390	309,390			26
27	Other (specify):*											27
28	TOTAL General Administration	574,574	74,145	5,705,060	6,353,779		6,353,779	1,885,341	8,239,120			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,676,770	1,368,409	6,862,071	17,907,250		17,907,250	2,617,088	20,524,338			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.

Facility Name & ID Number Sunny Hill Nrsg H of Will Co #0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			615,761	615,761		615,761		615,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30	30		30	(30)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			2,095	2,095		2,095		2,095			34
35	Rent-Equipment & Vehicles			34,359	34,359		34,359		34,359			35
36	Other (specify):*											36
37	**TOTAL Ownership**			652,245	652,245		652,245	(30)	652,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,996	998,772	1,147,768		1,147,768		1,147,768			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			523,910	523,910		523,910		523,910			42
43	Other (specify):* Non-Allowable Cos			7,337	7,337		7,337	(7,337)				43
44	**TOTAL Special Cost Centers**		148,996	1,530,019	1,679,015		1,679,015	(7,337)	1,671,678			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,676,770	1,517,405	9,044,335	20,238,510		20,238,510	2,609,721	22,848,231			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 Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,134)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,441)	20		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	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,575)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(994)	20		28
29	Other-Attach Schedule See Pg 5A	(27,944)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,118)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 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)	2,658,839		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,658,839		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 2,609,721		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Sunny Hill Nrsg H of Will Co

ID# 0014076

Report Period Beginning: 12/1/12

Ending: 11/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chamber of Commerce Dues	$ (1,445)	20	1
2	Lab Services	(6,343)	43	2
3	Disallow IHCA Lobbying Fees	(4,716)	20	3
4	Disallow non-allowable radiology services	(15,440)	10	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
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27				27
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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**	(27,944)		49

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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
Will County	100%	N/A		Will County	Joliet	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	$	Will County	100.00%	$ 750,320	$ 750,320	1
2	V	19	Professional Services		Will County	100.00%	984,152	984,152	2
3	V	21	Film Processing		Will County	100.00%	24,073	24,073	3
4	V	21	Telephone		Will County	100.00%	33,963	33,963	4
5	V	22	Employee Benefits		Will County	100.00%	556,941	556,941	5
6	V	26	Insurance		Will County	100.00%	309,390	309,390	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 2,658,839	$ * 2,658,839	14

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See attached list of	County board							$		1
2	board members	member	Administrative	0.00	None	<1 hour	0.00	N/A	None	N/A	2
3	No services have been provided to the nursing home by board members										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 Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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 [X] NO [ ]

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

Name of Related Organization: Will County
Street Address: 302 North Chicago
City / State / Zip Code: Joliet, IL 60432
Phone Number: (815) 740-4607
Fax Number: (815) 740-4319

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	% of Staff	1	1	$ 750,320	$	1	$ 750,320	1
2	19	Professional Services	% Hours / % Warrants	1	1	984,152		1	984,152	2
3	21	Film Processing	% State	1	1	24,073		1	24,073	3
4	21	Telephone	% Hours / % Warrants	1	1	33,963		1	33,963	4
5	22	Employee Benefits	% Employees	1	1	556,941		1	556,941	5
6	26	Insurance	% Employees	1	1	309,390		1	309,390	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					$ 2,658,839	$		$ 2,658,839	25

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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	Various		X	Finance Charges							30	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 30	9
	B. Non-Facility Related*											
10								Less: Non-Allowable Finance Charges			(30)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (30)	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)	2012	$	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
2009		9
2010		10
2011		11
2012	N/A	12

Not applicable - county does not pay real estate taxes.

	FOR BHF USE ONLY		
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 Hill Nrsg H of Will Co COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Karen Sobero, Administrator

TELEPHONE (815) 727-8710 FAX #: (815) 727-8637

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - County does not pay real estate taxes.		$	$
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 N/A 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.

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 116,410 B. General Construction Type: Exterior Brick Frame Steel/Concrete Block Number of Stories Two

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		1972	$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		1972	1972	$ 1,375,843	$	40	$	$	$ 1,375,843	4
5	140		1976	1976	1,198,083	29,952	40	29,952		1,123,200	5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing			1970	727		20			727	9
10	Landscaping			1972	51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance			1973	37,155		10-20			37,155	11
12	Door			1974	38,466		20			38,466	12
13	Asphalt Paving			1975	155,856		15			155,856	13
14	Landscaping			1976	57,254		10-15			57,254	14
15	Sewer and Water			1976	26,031		30			26,031	15
16	Plumbing			1972	183,817		25			183,817	16
17	Heating and Electrical			1972	522,443		20			522,443	17
18	Plumbing			1976	262,534		25			262,534	18
19	Heating and Electrical			1976	508,942		20			508,942	19
20	Sprinkler System and Paving			1975	83,460		25			83,460	20
21	Repairs / Roof			1981	107,858		15			107,858	21
22	Building Improvement			1987	819,813		25			819,813	22
23	Reroof A & B Roof			1985	85,920		20			85,920	23
24	Parking Lot Lights			1989	3,040		15			3,040	24
25	Reroof / Hot Water			1992	162,867		20			162,867	25
26	Washer Repair			1992	3,284		3			3,284	26
27	Site Improvements			1993	101,451		15			101,451	27
28	Laundry Renovation			1994	108,852		15			108,852	28
29	Paving Parking Lot			1995	66,260		15			66,260	29
30	Laundry, Air Conditioner			1996	362,815		12			362,815	30
31	Elevator Repair			1997	4,990		10			4,990	31
32	Tile			1992	7,040		5			7,040	32
33	Elevator Repair			1996	2,212		3			2,212	33
34	Sheeting			1993	3,685		3			3,685	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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	
37	Site improvement	1998	$ 2,936	$	10	$	$	$ 2,936	37
38	Electrical work	1998	2,085		10			2,085	38
39	Plumbing repair	1998	2,440		10			2,440	39
40	Boiler repair	1998	4,273		10			4,273	40
41	Fence	1999	1,000		10			1,000	41
42	Air Conditioning Repair	1999	6,284		10			6,284	42
43	Boiler repair	1999	4,965		10			4,965	43
44	Doors	1999	4,842		10			4,842	44
45	Carpeting	1999	1,649		10			1,649	45
46	Nurses Station	1999	53,554		10			53,554	46
47	Wallpaper	2000	840		10			840	47
48	Vinyl Board	2000	823		10			823	48
49	Office Compressor	2000	1,205		10			1,205	49
50	Fire System	2000	3,441		10			3,441	50
51	Fence	2000	936		10			936	51
52	Air Ducts	2000	3,090		10			3,090	52
53	Service Work	2000	1,573		10			1,573	53
54	Parking Lot	2000	4,860		10			4,860	54
55	Circular Pumps	2000	1,079		10			1,079	55
56	Boiler repair	2001	5,326		10			5,326	56
57									57
58	Plumbing	2002	11,756		10			11,756	58
59	Air Cleaner	2002	2,020		10			2,020	59
60	Boiler	2002	5,658		10			5,658	60
61	HVAC Control	2002	2,800		10			2,800	61
62	Fire and Smoke Dampers	2002	26,087		10			26,087	62
63	Doors	2002	4,155		10			4,155	63
64	Fireproof Framing	2002	2,730		10			2,730	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,504,680	$ 29,952		$ 29,952	$	$ 6,429,797	70

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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		$ 6,504,680	$ 29,952		$ 29,952	$	$ 6,429,797	1
2	HVAC	2003	11,370	568	10	568		11,370	2
3	Plumbing	2003	11,833	594	10	594		11,833	3
4	Oven repairs	2003	3,020	151	10	151		3,020	4
5	Dishwasher repairs	2003	1,419	70	10	70		1,419	5
6	Garbage disposal	2003	2,429	121	10	121		2,429	6
7	Freezer doors	2003	5,610	280	10	280		5,610	7
8	Boiler repairs	2003	21,892	1,096	10	1,096		21,892	8
9	Entrance door repairs	2003	13,240	662	10	662		13,240	9
10	Washing machine repair	2003	1,045	48	10	48		1,045	10
11	Site improvement	2003	8,252	414	10	414		8,252	11
12									12
13	Fire alarm system	2004	140,676	14,068	10	14,068		133,646	13
14	Water pipes replaced	2004	44,498	4,450	10	4,450		42,275	14
15	Structural work	2004	5,331	534	10	534		5,073	15
16	Windows	2004	29,590	2,960	10	2,960		28,120	16
17	Wall divider	2004	11,280	1,128	10	1,128		10,716	17
18	Front gate and posts	2004	8,025	802	10	802		7,619	18
19									19
20	Various lighting	2005	60,791	6,080	10	6,080		51,680	20
21	Cabinet	2005	1,200	120	10	120		1,020	21
22	Cabinet	2005	4,900	490	10	490		4,165	22
23	Pavement	2005	6,581	658	10	658		5,593	23
24	Stump removal and excavation	2005	12,600	1,260	10	1,260		10,710	24
25	Fire alarm modification	2005	4,286	428	10	428		3,638	25
26		2005	23,365	2,336	10	2,336		19,856	26
27	Remove & Replace concrete sidewalk for								27
28	front entrance to facility	2008	7,059	706	10	706		3,883	28
29									29
30	Remove & Replace doors	2009	15,489	3,098	5	3,098		13,166	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,960,461	$ 73,074		$ 73,074	$	$ 6,851,067	34

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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 12B, Carried Forward		$ 6,960,461	$ 73,074		$ 73,074	$	$ 6,851,067	1
2	1st Floor F-Wing	2009	3,215,133	80,378	40	80,378		361,701	2
3	- General Conditions								3
4	- Insurance								4
5	- OH&P								5
6	- Demolition, Asbestos removal								6
7	- Asbestos Abatement								7
8	- Materials (Steel)								8
9	- Rough Carpentry								9
10	- Millwork, Casework & Materials								10
11	- Caulking								11
12	- HM Doors & Hardware								12
13	- Glass & Glazing								13
14	- Windows, Installation & Trim								14
15	- Finish Carpentry								15
16	- Floor Cover, Demo, Patch								16
17	- Painting, Wall Coverings, Tape								17
18	- Toilet hardware & Accessories								18
19	- Cubical Curtains								19
20	- Signage								20
21	- Fire Extinguishers								21
22	- Sprinkler System								22
23	- Plumbing Demo								23
24	- Plumbing								24
25	- HVAC								25
26	- Electrical								26
27	- Contingency								27
28	- Contingency								28
29									29
30	Generator	2009	528,400	13,210	40	13,210		59,445	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,703,994	$ 166,662		$ 166,662	$	$ 7,272,213	34

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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 12C, Carried Forward		$ 10,703,994	$ 166,662		$ 166,662	$	$ 7,272,213	1
2	Lower Level E-Wing, Main Entrance & Canopy	2009	3,669,058	91,726	40	91,726		412,767	2
3	- General Conditions								3
4	- Insurance								4
5	- OH&P								5
6	- Demolition, Asbestos removal								6
7	- Asbestos Abatement								7
8	- Rough Carpentry								8
9	- Millwork, Casework & Materials								9
10	- Roofing								10
11	- Caulking								11
12	- HM Doors & Hardware								12
13	- Windows & Glazing								13
14	- Finish Carpentry								14
15	- Floor Coverings								15
16	- Painting, Wall Coverings, Tape								16
17	- Toilet hardware & Accessories								17
18	- Cubical Curtains								18
19	- Signage								19
20	- Fire Extinguishers								20
21	- Sprinkler System								21
22	- Plumbing Demo & Concrete								22
23	- Plumbing								23
24	- HVAC								24
25	- Electrical								25
26	- Contingency								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,373,052	$ 258,388		$ 258,388	$	$ 7,684,980	34

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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 12D, Carried Forward		$ 14,373,052	$ 258,388		$ 258,388	$	$ 7,684,980	1
2	1st Floor E-Wing	2009	3,077,955	76,949	40	76,949		346,270	2
3	- General Conditions								3
4	- Insurance								4
5	- OH&P								5
6	- Demolition, Asbestos removal								6
7	- Asbestos Abatement								7
8	- Materials (Steel)								8
9	- Rough Carpentry								9
10	- Millwork, Casework & Materials								10
11	- Caulking								11
12	- HM Doors & Hardware								12
13	- Glass & Glazing								13
14	- Windows, Installation & Trim								14
15	- Finish Carpentry								15
16	- Floor Cover, Demo, Patch								16
17	- Painting, Wall Coverings, Tape								17
18	- Toilet hardware & Accessories								18
19	- Cubical Curtains								19
20	- Signage								20
21	- Fire Extinguishers								21
22	- Sprinkler System								22
23	- Plumbing Demo								23
24	- Plumbing								24
25	- HVAC								25
26	- Electrical								26
27	- Contingency								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,451,007	$ 335,337		$ 335,337	$	$ 8,031,250	34

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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 12E, Carried Forward		$ 17,451,007	$ 335,337		$ 335,337	$	$ 8,031,250	1
2	1st Floor E-Wing	2010	57,230	1,431	40	1,431		5,008	2
3	- General Conditions								3
4	- OH&P								4
5	- Asbestos Abatement								5
6	- Rough Carpentry								6
7	- HVAC								7
8	- Electrical								8
9									9
10	Resident Room Remodel	2011	3,070,458	76,761	40	76,761		191,903	10
11	- General Conditions								11
12	- OH&P								12
13	- Asbestos Abatement								13
14	- Rough Carpentry								14
15	- Electrical								15
16	- plumbing								16
17									17
18	Tile floor resurfacing	2011	3,500	700	5	700		1,750	18
19									19
20	4th and 5th Avenue Remodel	2012	2,751,638	68,791	40	68,791		103,186	20
21	- General Conditions								21
22	- OH&P								22
23	- Sprinkler System								23
24	- Plumbing								24
25	- Electrical								25
26	- Rough Carpentry								26
27	- Fire Alarm								27
28	- Security System								28
29	- Nurse Call								29
30	- PA System								30
31	- HVAC								31
32									32
33	Tile floor resurfacing	2012	8,275	1,655	5	1,655		2,483	33
34	TOTAL (lines 1 thru 33)		$ 23,342,108	$ 484,675		$ 484,675	$	$ 8,335,580	34

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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 12F, Carried Forward		$ 23,342,108	$ 484,675		$ 484,675	$	$ 8,335,580	1
2									2
3	Therapy & Kitchen Interior Renovations, small entrance addition	2013	4,817,787	60,222	40	60,222		60,222	3
4	and parking renovations for therapy								4
5	-Painting								5
6	-Plumbing								6
7	-Electrical								7
8	-Equipment								8
9	- Mechanical								9
10	-General Construction								10
11	-Concrete Asphalt								11
12	-Excavation								12
13	-Millwork								13
14	-Landscaping								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)		$ 28,159,895	$ 544,897		$ 544,897	$	$ 8,395,802	34

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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	$ 459,262	$ 70,864	$ 70,864	$ (0)	5-10	$ 209,878	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	2,016,484					2,016,484	73
74								74
75	TOTALS	$ 2,475,746	$ 70,864	$ 70,864	$ (0)		$ 2,226,362	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	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 30,660,641	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 615,761	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 615,761	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,622,164	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Storage Unit				2,095			6
7	TOTAL				$ 2,095 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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	$

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: $ 34,359 Description: See Attached Sch 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

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

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

Sunny Hill Nursing Home
Provider # 0014076
12/01/12 - 11/30/13

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Helium tanks	$	1,047
Ice Machine		4,036
Dietary Equipment		7,664
Nursing Equipment		9,009
Oxygen Tanks		12,603
		34,359

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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

	1	2		3	4	5	6	7	8	
	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	39(3)	hrs	$	6355	$ 476,597	$	6,355	$ 476,597	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1474	110,526		1,474	110,526	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2,3)	hrs		5401	405,059	11,721	5,401	416,780	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				137,275		137,275	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			$		$ 992,182	$ 148,996	13,230	$ 1,141,178	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 Hill Nrsg H of Will Co **#** 0014076 **Report Period Beginning:** 12/1/12 **Ending:** 11/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/13 **(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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	21,715,747	21,715,747	15
16	Equipment, at Historical Cost	2,475,746	2,475,746	16
17	Accumulated Depreciation (book methods)	(10,622,164)	(10,622,164)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 20,038,477	$ 20,038,477	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 20,038,477	$ 20,038,477	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,149,833	1,149,833	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,149,833	$ 1,149,833	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,149,833	$ 1,149,833	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,888,644	$ 18,888,644	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 20,038,477	$ 20,038,477	48

***(See instructions.)**

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 14,732,949	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,732,949	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,033,813)	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)**	$ (6,033,813)	17
	B. Transfers (Itemize):		
18	**Interfund Transfers**	10,189,508	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 10,189,508	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 18,888,644	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,454,509	1
2	Discounts and Allowances for all Levels	948,948	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,403,457	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	662,809	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 662,809	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	3,134	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	104,278	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,485	19
20	Radiology and X-Ray	14,287	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 128,184	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Sundry	10,247	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,247	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,204,697	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,040,949	31
32	Health Care	8,512,522	32
33	General Administration	6,353,779	33
	B. Capital Expense		
34	Ownership	652,245	34
	C. Ancillary Expense		
35	Special Cost Centers	1,155,105	35
36	Provider Participation Fee	523,910	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,238,510	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,033,813)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,033,813)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,689,579	44
45	Private Pay - Net Inpatient Revenue	9,855,265	45
46	Medicare - Net Inpatient Revenue	1,858,613	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,403,457	49

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

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

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

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

^ - Government Entity - Part of County

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,969	2,089	$ 90,908	$ 43.52	1
2	Assistant Director of Nursing	3,522	3,876	137,580	35.50	2
3	Registered Nurses	49,527	57,420	1,841,986	32.08	3
4	Licensed Practical Nurses	64,292	72,068	1,847,284	25.63	4
5	CNAs & Orderlies	152,644	170,932	2,681,519	15.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,502	7,227	144,182	19.95	8
9	Activity Director					9
10	Activity Assistants	11,541	12,680	233,972	18.45	10
11	Social Service Workers	10,905	11,455	326,233	28.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	50,213	53,006	849,914	16.03	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	44,862	51,656	751,354	14.55	18
19	Laundry	11,778	13,562	197,264	14.55	19
20	Administrator	1,891	1,944	97,620	50.22	20
21	Assistant Administrator	2,411	2,549	88,490	34.72	21
22	Other Administrative	1,033	1,207	32,115	26.61	22
23	Office Manager					23
24	Clerical	14,753	16,402	356,349	21.73	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)	427,843	478,073	$ 9,676,770 *	$ 20.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 22,889	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	2,544	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,746	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	6,590	39(3)	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 54,769		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	835	$ 39,381	10(3)	50
51	Licensed Practical Nurses	7,195	312,605	10(3)	51
52	Certified Nurse Assistants/Aides	10,690	266,157	10(3)	52
53	TOTAL (lines 50 - 52)	18,720	$ 618,144		53

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Sobero	Administrator	0	$ 97,620
Rebecca Halderson	Asst. Administrator	0	88,490
Patricia Wendholt	Other Administrative	0	32,115
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 218,225

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	$ 28,305
AccuMed Services, Inc.	Medical Billing	11,495
Health Data Systems	Medical Billing	13,666
IVANS	Medical Billing	2,435
Medifax - EDI	Medical Billing	1,115
FR&R Healthcare	Accounting	235
McGladrey LLP	Accounting	13,335
Kronos	Payroll Services	11,042
MPRO	Healthcare Services	4,600
Wescom Solutions Inc	Computer Services	7,764
Ability Network Inc	Healthcare Services	1,142
Bank of Montreal	Cable Services	18
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 95,152

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	721,690
Employee Health Insurance	3,510,214
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,194,882
Uniforms	67,021
Employee Physicals/Drug Screenings	6,983
Allocation from County	556,942
TOTAL (agree to Schedule V, line 22, col.8)	$ 6,057,732

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 85)	1,019
Patient Background Checks 85	1,019
Illinois Healthcare Association	12,144
Miscellaneous Dues & Subscriptions	41,432
Chamber Dues	1,445
Less: Lobbying Fees	
Less: Chamber Dues	(1,445)
Less: Public Relations Expense	(4,716)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,898

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,523
See Attached Schedule	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,523

* Attach copy of IMRF notifications

**See instructions.

Sunny Hill Nursing Home
Provider # 0014076
12/01/12 - 11/30/13

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Subtotal	95,152
Total (agree to Schedule V, line 19, column 3)	95,152
Allocated from Will County	984,152
Disallow Bank of Montreal	(18)
Total (agree to Schedule V, line 19, column 8)	1,079,286

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

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

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

Facility Name & ID Number Sunny Hill Nrsg H of Will Co # 0014076 Report Period Beginning: 12/1/12 Ending: 11/30/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $12,144**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **179,057** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **523,910**
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 tc
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **3,134**

(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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Baker Tilly**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
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