

Facility Name & ID Number Sunny Hill Nsg H of Will Co

0014076 Report Period Beginning: 12/1/2013 Ending: 11/30/2014

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	43,911	9,746	11,438	65,095	8
9	SNF/PED					9
10	ICF	1,647			1,647	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,558	9,746	11,438	66,742	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.31%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 1972

J. Was the facility purchased or leased after January 1, 1978?

YES Date N/A NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 280 and days of care provided 4,108

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/14 Fiscal Year: 11/30/14

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

Facility Name & ID Number

Sunny Hill Nsg H of Will Co

0014076

Report Period Beginning:

12/1/2013

Ending:

11/30/2014

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	850,914	45,486	72,505	968,905		968,905		968,905		1
2	Food Purchase		537,030		537,030		537,030	(1,190)	535,840		2
3	Housekeeping	751,225	93,809		845,034		845,034		845,034		3
4	Laundry	196,800	55,777		252,577		252,577		252,577		4
5	Heat and Other Utilities			316,947	316,947		316,947		316,947		5
6	Maintenance		4,290	119,728	124,018		124,018	768,774	892,792		6
7	Other (specify):*										7
8	TOTAL General Services	1,798,939	736,392	509,180	3,044,511		3,044,511	767,584	3,812,095		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	6,844,198	485,791	768,734	8,098,723		8,098,723	(17,758)	8,080,965		10
10a	Therapy	181,953			181,953		181,953		181,953		10a
11	Activities	261,861			261,861		261,861		261,861		11
12	Social Services	305,181			305,181		305,181		305,181		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,593,193	485,791	774,734	8,853,718		8,853,718	(17,758)	8,835,960		16
	C. General Administration										
17	Administrative	241,123			241,123		241,123		241,123		17
18	Directors Fees										18
19	Professional Services			106,156	106,156		106,156	1,129,151	1,235,307		19
20	Dues, Fees, Subscriptions & Promotions			46,241	46,241		46,241	(24,257)	21,984		20
21	Clerical & General Office Expenses	374,128	42,677	24,616	441,421		441,421	57,491	498,912		21
22	Employee Benefits & Payroll Taxes			5,735,372	5,735,372		5,735,372	439,949	6,175,321		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,275	3,275		3,275		3,275		24
25	Other Admin. Staff Transportation			1,804	1,804		1,804		1,804		25
26	Insurance-Prop.Liab.Malpractice							304,469	304,469		26
27	Other (specify):*										27
28	TOTAL General Administration	615,251	42,677	5,917,464	6,575,392		6,575,392	1,906,803	8,482,195		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,007,383	1,264,860	7,201,378	18,473,621		18,473,621	2,656,629	21,130,250		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			707,860	707,860	707,860		707,860				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			57,154	57,154	57,154		57,154				35
36	Other (specify):*											36
37	TOTAL Ownership			765,014	765,014	765,014		765,014				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		133,329	871,409	1,004,738	1,004,738		1,004,738				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			540,072	540,072	540,072		540,072				42
43	Other (specify):* Non-Allowable Co			11,442	11,442	11,442	(11,442)					43
44	TOTAL Special Cost Centers		133,329	1,422,923	1,556,252	1,556,252	(11,442)	1,544,810				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,007,383	1,398,189	9,389,315	20,794,887	20,794,887	2,645,187	23,440,074				45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,190)	2		4
5	Telephone, TV & Radio in Resident Rooms	(19,573)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,628)	19		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	(1,750)	20		28
29	Other-Attach Schedule See Page 5A	(32,134)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,275)		\$	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	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)	2,710,462		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,710,462		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,645,187		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Sunny Hill Nsg H of Will Co

ID# 0014076

Report Period Beginning: 12/1/2013

Ending: 11/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Chamber of Commerce Dues	\$ (410)	20	1
2	Lab Services	(9,692)	43	2
3	Disallow IHCA Lobbying Fees	(4,274)	20	3
4	Disallow non-allowable radiology services	(17,758)	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
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(32,134)	49

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
<u>Will County</u>	<u>100%</u>	<u>N/A</u>		<u>Will County</u>	<u>Joliet</u>	<u>Government</u>

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>6 Maintenance</u>	\$	<u>Will County</u>	<u>100.00%</u>	<u>\$ 768,774</u>	<u>\$ 768,774</u>	<u>1</u>
2	V	<u>19 Professional Services</u>		<u>Will County</u>	<u>100.00%</u>	<u>1,139,779</u>	<u>1,139,779</u>	<u>2</u>
3	V	<u>21 Film Processing</u>		<u>Will County</u>	<u>100.00%</u>	<u>24,741</u>	<u>24,741</u>	<u>3</u>
4	V	<u>21 Telephone</u>		<u>Will County</u>	<u>100.00%</u>	<u>32,750</u>	<u>32,750</u>	<u>4</u>
5	V	<u>22 Employee Benefits</u>		<u>Will County</u>	<u>100.00%</u>	<u>439,949</u>	<u>439,949</u>	<u>5</u>
6	V	<u>26 Insurance</u>		<u>Will County</u>	<u>100.00%</u>	<u>304,469</u>	<u>304,469</u>	<u>6</u>
7	V							<u>7</u>
8	V							<u>8</u>
9	V							<u>9</u>
10	V							<u>10</u>
11	V							<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	Total		\$			<u>\$ 2,710,462</u>	<u>\$ * 2,710,462</u>	<u>14</u>

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

Facility Name & ID Number Sunny Hill Nsg H of Will Co # 0014076 Report Period Beginning: 12/1/2013 Ending: 11/30/2014

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	See attached list of	County board							\$	1
2	board members	member	Administrative	0.00	None	<1 hour	0.00	N/A	None	N/A
3	No services have been provided to the nursing home by board members									
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 Nsg H of Will Co

0014076 Report Period Beginning: 12/1/2013

Ending: 1/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	% of Staff	1	\$ 768,774	\$	1	\$ 768,774	1
2	19	Professional Services	% Hours / % Warrants	1	1,139,779		1	1,139,779	2
3	21	Film Processing	% State	1	24,741		1	24,741	3
4	21	Telephone	% Hours / % Warrants	1	32,750		1	32,750	4
5	22	Employee Benefits	% Employees	1	439,949		1	439,949	5
6	26	Insurance	% Employees	1	304,469		1	304,469	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				\$ 2,710,462	\$		\$ 2,710,462	25

Facility Name & ID Number

Sunny Hill Nsg H of Will Co

0014076

Report Period Beginning:

12/1/2013

Ending:

11/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	N/A						\$	\$			\$					
2																
3																
4																
5																
Working Capital																
6	N/A															
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
B. Non-Facility Related*																
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 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.)		2013		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2014 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.)			Allocated from Management Co.	\$	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:	2009	_____	8	FOR BHF USE ONLY	
	2010	_____	9		
	2011	_____	10		
	2012	N/A	11		
	2013	_____	12		
Not applicable - county does not pay real estate taxes.					
				13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____ 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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Hill Nsg 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 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A - County does not pay real estate taxes.</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u></u></u>	\$ <u><u></u></u>

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

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

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

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

N/A

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

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

Nature of Costs: _____
 (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	<u>Resident Care</u>		<u>1972</u>	<u>\$ 25,000</u>	1
2					2
3	TOTALS			\$ 25,000	3

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	140	1972	1972	\$ 1,375,843	\$	40	\$	\$	\$ 1,375,843	4
5	140	1976	1976	1,198,083	29,952	40	29,952		1,153,152	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 Nsg H of Will Co

0014076

Report Period Beginning:

12/1/2013

Ending:

11/30/2014

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	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	\$	\$ 6,459,749	70

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

Facility Name & ID Number Sunny Hill Nsg H of Will Co

0014076

Report Period Beginning:

12/1/2013

Ending:

11/30/2014

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	
1	Totals from Page 12A, Carried Forward		\$ 6,504,680	\$ 29,952		\$ 29,952	\$	\$ 6,459,749	1
2	HVAC	2003	11,370		10			11,370	2
3	Plumbing	2003	11,833		10			11,833	3
4	Oven repairs	2003	3,020		10			3,020	4
5	Dishwasher repairs	2003	1,419		10			1,419	5
6	Garbage disposal	2003	2,429		10			2,429	6
7	Freezer doors	2003	5,610		10			5,610	7
8	Boiler repairs	2003	21,892		10			21,892	8
9	Entrance door repairs	2003	13,240		10			13,240	9
10	Washing machine repair	2003	1,045		10			1,045	10
11	Site improvement	2003	8,252		10			8,252	11
12									12
13	Fire alarm system	2004	140,676	7,030	10	7,030		140,676	13
14	Water pipes replaced	2004	44,498	2,223	10	2,223		44,498	14
15	Structural work	2004	5,331	258	10	258		5,331	15
16	Windows	2004	29,590	1,470	10	1,470		29,590	16
17	Wall divider	2004	11,280	564	10	564		11,280	17
18	Front gate and posts	2004	8,025	406	10	406		8,025	18
19									19
20	Various lighting	2005	60,791	6,080	10	6,080		57,760	20
21	Cabinet	2005	1,200	120	10	120		1,140	21
22	Cabinet	2005	4,900	490	10	490		4,655	22
23	Pavement	2005	6,581	658	10	658		6,251	23
24	Stump removal and excavation	2005	12,600	1,260	10	1,260		11,970	24
25	Fire alarm modification	2005	4,286	428	10	428		4,066	25
26		2005	23,365	2,336	10	2,336		22,192	26
27	Remove & Replace concrete sidewalk for								27
28	front entrance to facility	2008	7,059	706	10	706		4,589	28
29									29
30	Remove & Replace doors	2009	15,489	2,323	5	2,323		15,489	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,960,461	\$ 56,304		\$ 56,304	\$	\$ 6,907,371	34

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

Facility Name & ID Number Sunny Hill Nsg H of Will Co

0014076

Report Period Beginning:

12/1/2013

Ending:

11/30/2014

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	
1	Totals from Page 12B, Carried Forward		\$ 6,960,461	\$ 56,304		\$ 56,304	\$	\$ 6,907,371	1
2	1st Floor F-Wing	2009	3,215,133	80,378	40	80,378		442,079	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		72,655	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,703,994	\$ 149,892		\$ 149,892	\$	\$ 7,422,105	34

**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 12C, Carried Forward		\$ 10,703,994	\$ 149,892		\$ 149,892	\$	\$ 7,422,105	1
2	Lower Level E-Wing, Main Entrance & Canopy	2009	3,669,058	91,726	40	91,726		504,493	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	\$ 241,618		\$ 241,618	\$	\$ 7,926,598	34

**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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 14,373,052	\$ 241,618		\$ 241,618	\$	\$ 7,926,598	1
2	1st Floor E-Wing	2009	3,077,955	76,949	40	76,949		423,219	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	\$ 318,567		\$ 318,567	\$	\$ 8,349,817	34

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

Facility Name & ID Number Sunny Hill Nsg H of Will Co

0014076

Report Period Beginning:

12/1/2013

Ending:

11/30/2014

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	
1	Totals from Page 12E, Carried Forward		\$ 17,451,007	\$ 318,567		\$ 318,567	\$	\$ 8,349,817	1
2	1st Floor E-Wing	2010	57,230	1,431	40	1,431		6,439	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		268,664	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		2,450	18
19									19
20	4th and 5th Avenue Remodel	2012	2,751,638	68,791	40	68,791		171,977	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		4,138	33
34	TOTAL (lines 1 thru 33)		\$ 23,342,108	\$ 467,905		\$ 467,905	\$	\$ 8,803,485	34

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

Facility Name & ID Number Sunny Hill Nsg H of Will Co

0014076

Report Period Beginning:

12/1/2013

Ending:

11/30/2014

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	
1	Totals from Page 12F, Carried Forward		\$ 23,342,108	\$ 467,905		\$ 467,905	\$	\$ 8,803,485	1
2									2
3	Therapy & Kitchen Interior Renovations, small entrance addition	2013	4,817,787	120,445	40	120,445		180,667	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	Therapy & Kitchen Renovations, 6th Avenue and Admin.	2014	3,318,956	41,487	40	41,487		41,487	16
17	patient wing, dining room and administrative areas								17
18	-Fire Protections								18
19	-Plumbing								19
20	-Painting								20
21	-Asbestos Abatement								21
22	-Electrical								22
23	-General Construction								23
24	-Excavation								24
25	-Millwork								25
26	-Landscaping								26
27	-HVAC								27
28	-Elevator Modernization								28
29	-Access Road Rehabilitation								29
30	-Concrete Asphalt								30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 31,478,851	\$ 629,837		\$ 629,837	\$	\$ 9,025,639	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	\$ 459,262	\$ 70,864	\$ 70,864	\$	5	\$ 280,742	71
72	Current Year Purchases	71,590	7,159	7,159		5	7,159	72
73	Fully Depreciated Assets	2,016,484				5	2,016,484	73
74								74
75	TOTALS	\$ 2,547,336	\$ 78,023	\$ 78,023	\$		\$ 2,304,385	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)	\$ 34,051,187	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 707,860	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 707,860	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,330,024	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 Nsg H of Will Co

0014076

Report Period Beginning: 12/1/2013

Ending: 11/30/2014

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								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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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 N/A.

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 57,154 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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name: Sunny Hill Nsg H of Will Co
IDPH License ID Number: 0014076
Fiscal Year End: 11/30/2014

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Helium tanks	873
Ice Machine	6,330
Dietary Equipment	11,425
Nursing Equipment	17,679
Oxygen Tanks	20,847
Total - Line 16	<u>57,154</u>

Facility Name & ID Number Sunny Hill Nsg H of Will Co # 0014076 Report Period Beginning: 12/1/2013 Ending: 11/30/2014
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,167	\$ 312,558	\$	4,167	\$ 312,558	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,033	77,475		1,033	77,475	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(2,3)	hrs		6,346	475,960	10,845	6,346	486,805	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescripts				122,484		122,484	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			\$	11,546	\$ 865,993	\$ 133,329	11,546	\$ 999,322	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 Nsg H of Will Co

0014076

Report Period Beginning: 12/1/2013

Ending:

11/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2014

(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	25,034,703	25,034,703	15
16	Equipment, at Historical Cost	2,547,336	2,547,336	16
17	Accumulated Depreciation (book methods)	(11,330,024)	(11,330,024)	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 (spec			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,721,163	\$ 22,721,163	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,721,163	\$ 22,721,163	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	1,233,024	1,233,024	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)	\$ 1,233,024	\$ 1,233,024	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)	\$ 1,233,024	\$ 1,233,024	46
47	TOTAL EQUITY(page 18, line 24)	\$ 21,488,139	\$ 21,488,139	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 22,721,163	\$ 22,721,163	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,888,644	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,888,644	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(5,549,972)	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)	\$ (5,549,972)	17
B. Transfers (Itemize):			
18	Interfund Transfers	8,149,467	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 8,149,467	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 21,488,139	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	\$ 13,480,748	1
2	Discounts and Allowances for all Levels	768,530	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,249,278	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	852,240	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 852,240	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	1,190	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	117,289	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,978	19
20	Radiology and X-Ray	14,263	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 139,720	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Sundry</u>	3,677	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,677	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,244,915	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,044,511	31
32	Health Care	8,853,718	32
33	General Administration	6,575,392	33
B. Capital Expense			
34	Ownership	765,014	34
C. Ancillary Expense			
35	Special Cost Centers	1,016,180	35
36	Provider Participation Fee	540,072	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,794,887	40
41	Income before Income Taxes (line 30 minus line 40)**	(5,549,972)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,549,972)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,007,725	44
45	Private Pay - Net Inpatient Revenue	10,589,803	45
46	Medicare - Net Inpatient Revenue	1,651,750	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,249,278	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.

^ - This entity is a cash basis taxpayer"

Facility Name & ID Number Sunny Hill Nsg H of Will Co

0014076

Report Period Beginning: 12/1/2013

Ending:

11/30/2014

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	1,976	2,140	\$ 94,999	\$ 44.39	1
2	Assistant Director of Nursing	5,573	5,781	209,296	36.20	2
3	Registered Nurses	56,086	61,911	2,025,761	32.72	3
4	Licensed Practical Nurses	57,564	66,427	1,736,753	26.15	4
5	CNAs & Orderlies	156,503	173,572	2,777,389	16.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,997	8,941	181,953	20.35	8
9	Activity Director					9
10	Activity Assistants	12,643	13,913	261,861	18.82	10
11	Social Service Workers	9,470	10,506	305,181	29.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	49,881	52,027	850,914	16.36	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	44,585	50,635	751,225	14.84	18
19	Laundry	11,623	13,265	196,800	14.84	19
20	Administrator	1,825	2,072	107,393	51.83	20
21	Assistant Administrator	2,472	2,747	97,272	35.41	21
22	Other Administrative	1,165	1,344	36,458	27.13	22
23	Office Manager					23
24	Clerical	15,276	16,883	374,128	22.16	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					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	434,639	482,164	\$ 10,007,383 *	\$ 20.76	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 24,155	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	2,506	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,379	10(3)	39
40	Physical Therapy Consultant	Monthly	481	39(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	4,935	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)		\$ 48,456		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	425	\$ 20,445	10(3)	50
51	Licensed Practical Nurses	11,452	507,519	10(3)	51
52	Certified Nurse Assistants/Aides	8,211	208,532	10(3)	52
53	TOTAL (lines 50 - 52)	20,088	\$ 736,496		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		
Karen Sobero	Administrator	0	\$ 107,393	Workers' Compensation Insurance	\$	IDPH License Fee	\$ 1,990		
Rebecca Halderson	Asst. Administrator	0	97,272	Unemployment Compensation Insurance		Advertising: Employee Recruitment			
Patricia Wendholt	Other Administrative	0	36,458	FICA Taxes	742,986	Health Care Worker Background Check			
				Employee Health Insurance	3,699,295	(Indicate # of checks performed 67)	799		
				Employee Meals		Patient Background Checks	67 799		
				Illinois Municipal Retirement Fund (IMRF)*	1,223,176	Illinois Healthcare Association	11,132		
				Uniforms	63,640	Miscellaneous Dues & Subscriptions	11,539		
				Employee Physicals/Drug Screenings	6,275	Chamber Dues	410		
						Less: Lobbying Fees	(4,274)		
						Less: Chamber Dues	(410)		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 241,123	Allocation from County	439,949	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,984	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
N/A			\$						
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			Description		
Vendor/Payee	Type	Amount		Description	Line #	Amount		Amount	
See Attached Schedule 21C	See Sch. 21C	\$ 106,156		N/A		\$		Out-of-State Travel	\$
								In-State Travel	
								Seminar Expense	3,275
								Entertainment Expense	()
								(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 106,156	TOTAL			\$	TOTAL	\$ 3,275

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Tabor Hills Health Care Facility, Inc.
IDPH License ID Number: 0040543
Fiscal Year End: 1/0/1900

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Duane Morris	Legal	10,628
AccuMed	Computer Services	625
Health Data Systems	Computer Services	10,500
Pathway Health Services	Computer Services	4,425
Emdeon/Medifax-EDI, Inc	Medical Billing	854
James Grennan	Healthcare Services	90
McGladrey	Accounting	25,255
Kronos	Payroll Services	7,665
Provinet Solutions	Computer Services	1,329
Wescom Solutions Inc	Computer Services	26,727
Ability Network Inc	Healthcare Services	5,710
Integrated Systems	Computer Services	115
Passport Health	Healthcare Services	99
Relias Learning	Healthcare Services	12,134
Total (agree to Schedule V, line 19, column 3)		<u><u>106,156</u></u>
Allocated from Management Company Professional Services		1,139,779
Less: Non-Allowable Legal Fees		(10,628)
Total (agree to Schedule V, line 19, column 8)		<u><u>1,235,307</u></u>

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3											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 Nsg H of Will Co

0014076

Report Period Beginning: 12/1/2013

Ending: 11/30/2014

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 - \$11,132
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 151,671 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 540,072
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,190
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Baker Tilly
- (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.