

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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.

<p>I. IDPH License ID Number: <u>0005009</u></p> <p>Facility Name: <u>Sunny Acres Nursing Home</u></p> <p>Address: <u>19130 Sunny Acres Rd</u> <u>Petersburg</u> <u>62675</u> Number City Zip Code</p> <p>County: <u>Menard</u></p> <p>Telephone Number: <u>217-632-2334</u> Fax # <u>217-632-7092</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1966</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: _____ Telephone Number: <u>309823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/14</u> to <u>11/30/15</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David M Underwood</u></td> </tr> <tr> <td>(Title) <u>EVP & CFO</u></td> </tr> <tr> <td rowspan="5" style="width: 15%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP & CFO</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) (____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County																																	
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																	
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	<input type="checkbox"/> Limited Liability Co.	_____																																	
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Paid Preparer	(Signed) _____																																		
	(Date) _____																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) (____) _____ Fax # (____) _____																																		

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning: 12/01/14 Ending: 11/30/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,383	14,100	3,133	31,616	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,383	14,100	3,133	31,616	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.72%

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

0 (Do not include bed-hold days in Section B.)

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

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

meals for menard county inmates

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

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

YES NO

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

YES NO

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

Date started 12/01/1966

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 106 and days of care provided 3,133

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

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	245,573	20,261		265,834		265,834	265,834			1
2	Food Purchase		228,097		228,097		228,097	228,097			2
3	Housekeeping	229,355	45,747		275,102		275,102	275,102			3
4	Laundry	7,899	14,362		22,261		22,261	22,261			4
5	Heat and Other Utilities			134,284	134,284		134,284	134,284			5
6	Maintenance	83,785	87,072	47,345	218,202		218,202	218,202			6
7	Other (specify):*										7
8	TOTAL General Services	566,612	395,539	181,629	1,143,780		1,143,780	1,143,780			8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	2,038,170	175,820	8,698	2,222,688		2,222,688	2,222,688			10
10a	Therapy		171,830	709,577	881,407	(209,194)	672,213	672,213			10a
11	Activities	98,812	9,005		107,817		107,817	107,817			11
12	Social Services	24,147		3,794	27,941		27,941	27,941			12
13	CNA Training	5,943	860		6,803		6,803	6,803			13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,167,072	357,515	734,069	3,258,656	(209,194)	3,049,462	3,049,462			16
	C. General Administration										
17	Administrative	93,068			93,068		93,068	93,068			17
18	Directors Fees										18
19	Professional Services			333,155	333,155		333,155	(9,160)	323,995		19
20	Dues, Fees, Subscriptions & Promotions			98,724	98,724	(57,488)	41,236	(26,986)	14,250		20
21	Clerical & General Office Expenses	346,261	69,823	11,886	427,970		427,970	427,970			21
22	Employee Benefits & Payroll Taxes			751,835	751,835		751,835	751,835			22
23	Inservice Training & Education			200	200		200	200			23
24	Travel and Seminar			9,613	9,613		9,613	(4,614)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			82,990	82,990		82,990	82,990			26
27	Other (specify):*										27
28	TOTAL General Administration	439,329	69,823	1,288,403	1,797,555	(57,488)	1,740,067	(40,760)	1,699,307		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,173,013	822,877	2,204,101	6,199,991	(266,682)	5,933,309	(40,760)	5,892,549		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			187,163	187,163		187,163		187,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(11,102)	(11,102)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,706	7,706		7,706		7,706			35
36	Other (specify):*											36
37	TOTAL Ownership			194,869	194,869		194,869	(11,102)	183,767			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					209,194	209,194		209,194			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					57,488	57,488		57,488			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					266,682	266,682		266,682			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,173,013	822,877	2,398,970	6,394,860		6,394,860	(51,862)	6,342,998			45

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/01/14

Ending: 11/30/15

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-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,102)			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	(4,614)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,160)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(26,986)			25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,862)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (51,862)		37

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

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

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

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12/01/14

Ending: 11/30/15

Sch. V Line Reference

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(9,160)	19	22
23				23
24		0	27	24
25		(26,986)	20	25
26				26
27		0	22	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		(36,146)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,160)	0	0	0	0	0	0	0	0	0	0	(9,160)	19
20	Fees, Subscriptions & Promotions	(26,986)	0	0	0	0	0	0	0	0	0	0	(26,986)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,614)	0	0	0	0	0	0	0	0	0	0	(4,614)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(40,760)	0	0	0	0	0	0	0	0	0	0	(40,760)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,760)	0	0	0	0	0	0	0	0	0	0	(40,760)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Acres Nursing Home# 0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,102)	0	0	0	0	0	0	0	0	0	0	(11,102)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,102)	0	0	0	0	0	0	0	0	0	0	(11,102)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(51,862)	0	0	0	0	0	0	0	0	0	0	(51,862)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Menard County, Illinois	100			Countryside Estates of Menard County		Independent Living

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

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

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

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

Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	List of Board Commissioner and							2
3	Nursing Home Advisory Committee							3
4	is attached							4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12/01/14 Ending: 11/30/15

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	No compensation or other								\$	1
2	payments made									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning: 12/01/14 Ending: 11/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

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**					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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10	Interest Income										(11,102)						
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			(11,102)						
15	TOTALS (line 9+line14)						\$	\$			(11,102)						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # _____

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

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

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 2014 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$	#VALUE!		3
4.	Real Estate Tax accrual used for 2015 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.	\$	#VALUE!		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	12	
Not Applicable					
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2014 \$		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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Acres Nursing Home COUNTY Menard

FACILITY IDPH LICENSE NUMBER 0005009

CONTACT PERSON REGARDING THIS REPORT David M Underwood

TELEPHONE 309-823-7135 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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.	None		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Acres Nursing Home

0005009 Report Period Beginning:

12/01/14 Ending:

11/30/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

Countryside Estates of the County is an independent living facility located adjacent to Sunny Acres Nursing Home. The financial operations of Countryside Estates of the County are accounted for in a separate and distinct Menard County fund, as are the financial operations of Sunny Acres Nursing Home.

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>County owns land that the nursing home</u>			\$	1
2	<u>and independent living facility are situated on</u>				2
3	TOTALS			\$	3

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

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	105		1966	1966	\$ 526,787	\$		\$	\$	\$	4
5			1977	1977	568,714						5
6			1984	1984	61,842						6
7			1993	1993	654,160						7
8			1995	1995	68,999						8
	Improvement Type**										
9		generator		1980	28,901						9
10		fire alarm system		1981	9,805						10
11		none		1982							11
12		gazebo and floor coverings		1983	12,750						12
13		flooring, phone, and paging systems, air conditioner		1984	30,885						13
14		sun room, remodelling, wall paper		1985	7,061						14
15		kitchen remodelling, wallpaper, parking lot, nightlight, etc		1986	36,333						15
16		boiler repair, sprinkler system, office remodelling		1987	17,193						16
17		roof, chimney, carpeting, sprinkler system		1988	147,826						17
18		compressor, canopy, carport		1989	6,472						18
19		asbestos removal, flooring, water heater, landscaping, canopy		1990	28,642						19
20		main air conditioning unit		1991	5,194						20
21		none		1992							21
22		new lagoon, tiling, hot wate heater, aviary		1993	223,851						22
23		fill old lagoon, flooring, wallpaper, and signs		1994	49,671						23
24		major boiler repair, air conditioners, ceiling tile replacement		1995	10,685						24
25		special needs unit, resident walking gardens, vinyl soffets		1996	139,517						25
26		donor recognition, wall, remodelling, draperies, and shades		1997	20,798						26
27		major boiler repair, air conditioners, ceiling tile replacement		1998	21,699						27
28		two commercial water hearters, entrybath, rooftop		1999	41,844						28
29		plumbing, improvements, stuctural improvement		2000	18,896						29
30		plumbing, electrical, boiler rehabilitation		2001	22,162						30
31		structural improvements, sewer lines and walls		2002	77,846						31
32		seal parking lot, fences improvements		2003	16,183						32
33		flooring, alarm systems, office remodelling		2004	67,361						33
34		kitchen tile and ceiling, carpeting, drapes, circuit improvements		2005	17,161						34
35		entrance improvements, wiring cable system, front doors		2006	45,926						35
36		carpeting, vinyl flooring for resident rooms		2007	13,077						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	sprinkler system in progress	2007	\$ 6,128	\$		\$	\$	\$	37
38	front walk and handrails	2007	19,000						38
39	hot water heater	2007	3,823						39
40	foam roofing system	2007	141,519						40
41	draft inducer and heater	2007	4,577						41
42	lockinvar water heater	2007	5,289						42
43	extend sprinkler system	2008	169,566						43
44	replace boiler and cooling system	2009	388,232						44
45	alarm system for building	2009	30,000						45
46	bath entry	2009	5,460						46
47	back flow preventer	2009	3,602						47
48	vinyl flooring for resident rooms	2009	3,406						48
49	frame up pictures	2009	3,842						49
50	air unit compressor	2009	4,447						50
51	office improvements carpet, walls	2010	4,491						51
52	vinyl floor replacement for resident rooms	2011	9,594						52
53	window replacement	2011	128,150						53
54	soffets and fascia replacement	2011	39,732						54
55	window replacement	2012	1,263						55
56	100 gallon hot water heater replacement	2012	9,100						56
57	vinyl floor covering for resident rooms	2012	11,552						57
58	emergency generator replacement	2013	225,525						58
59	sewer waste line improvement	2013	12,980						59
60	vinyl floor covering for resident rooms	2013	5,642						60
61	resident rooms and office painting	2014	41,690						61
62	flooring for resident rooms	2014	13,141						62
63	magnetic holders and compressor and fans etc	2014	9,829						63
64	hard wiring for new IT system	2015	8,935						64
65	roof replacement - in progress	2015	183,816						65
66									66
67				125,629		125,629		3,091,792	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,492,572	\$ 125,629		\$ 125,629	\$	\$ 3,091,792	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 553,924	\$ 56,853	\$ 56,853	\$		\$ 410,333	71
72	Current Year Purchases	44,297	4,681	4,681			4,681	72
73	Fully Depreciated Assets	780,196					780,196	73
74								74
75	TOTALS	\$ 1,378,417	\$ 61,534	\$ 61,534	\$		\$ 1,195,210	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	facility operations	1989 van	1989	\$ 22,320	\$	\$	\$		\$ 22,320	76
77	facility operations	2006 ford supreme van	2006	44,625					44,625	77
78	facility operations	pickup truck	2006	6,120					6,120	78
79										79
80	TOTALS			\$ 73,065	\$	\$	\$		\$ 73,065	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,944,054	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,163	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 187,163	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)	\$ 4,360,067	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/01/14

Ending: 11/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,706

Description: Televisions

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12/01/14 Ending: 11/30/15
 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? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 304,140	\$		\$ 304,140	1
2	Licensed Speech and Language Development Therapist		hrs				38,333			38,333	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				329,740	0		329,740	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts					171,830		171,830	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						37,364			37,364	13
14	TOTAL			\$			\$ 709,577	\$ 171,830		\$ 881,407	14

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12/01/14

Ending:

11/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/15

(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	\$ 4,564,609	\$	1
2	Cash-Patient Deposits	17,758		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	686,003		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,370		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	578,689		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,868,429	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,492,572		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,451,481		16
17	Accumulated Depreciation (book methods)	(4,360,067)		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)	\$ 1,583,986	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,452,415	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 496,805	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,758		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	350,521		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,466		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	39,642		36
37	<u>Accrued Expenses</u>	21,188		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 938,380	\$	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)	\$ 938,380	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,514,035	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,452,415	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,303,621	1
2	Restatements (describe):		2
3	Properly reflect bequest	475,000	3
4	Adjust allowance for doubtful accounts - prior year activity	(1,189,220)	4
5	Adjust general ledger balances to actual	13,935	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,603,336	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(29,301)	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)	\$ (29,301)	17
B. Transfers (Itemize):			
18	To Menard County General Fund	(60,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (60,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,514,035	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,854,280	1
2	Discounts and Allowances for all Levels	(2,075,208)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,779,072	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,196,316	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,196,316	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	259,283	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,786	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 264,069	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,102	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Contribution Income	115,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 115,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,365,559	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,143,780	31
32	Health Care	3,258,656	32
33	General Administration	1,797,555	33
B. Capital Expense			
34	Ownership	194,869	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,394,860	40
41	Income before Income Taxes (line 30 minus line 40)**	(29,301)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (29,301)	43

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

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

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

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

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	1,919	2,132	\$ 73,654	\$ 34.55	1
2	Assistant Director of Nursing	1,968	2,187	36,533	16.70	2
3	Registered Nurses	6,566	7,296	207,025	28.38	3
4	Licensed Practical Nurses	26,341	29,268	703,703	24.04	4
5	CNAs & Orderlies	71,415	79,350	1,017,255	12.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	6,482	7,202	98,812	13.72	10
11	Social Service Workers	1,919	2,132	24,147	11.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,601	22,890	245,573	10.73	15
16	Dishwashers					16
17	Maintenance Workers	5,913	6,570	83,785	12.75	17
18	Housekeepers	20,767	23,074	229,355	9.94	18
19	Laundry	848	942	7,899	8.39	19
20	Administrator	1,872	2,080	93,068	44.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,183	20,203	346,261	17.14	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)	184,794	205,326	\$ 3,167,070 *	\$ 15.42	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	2,970		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,426		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	3,794		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,190		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Dianne Cochran			\$ 93,068	Workers' Compensation Insurance	\$ 141,877	IDPH License Fee	\$		
				Unemployment Compensation Insurance	(3,166)	Advertising: Employee Recruitment		3,340	
				FICA Taxes	242,281	Health Care Worker Background Check (Indicate # of checks performed)		2,822	
				Employee Health Insurance	118,427	Patient Background Checks			
				Employee Meals		PR		3,293	
				Illinois Municipal Retirement Fund (IMRF)*	232,004	Dues & Subscriptions		6,726	
				Other Benefits	20,412	License & Fees		1,362	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,068	TOTAL (agree to Schedule V, line 22, col.8)			\$ 751,835	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
								8,160	
								0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	1,453	
								(4,614)	
C. Professional Services							Entertainment Expense	(
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	\$ 4,999	
Heritage Operations Group	Management		\$ 277,678						
Michael J Feriozzi CPA	Audit & Accounting		28,294						
Revere Healthcare LTD	Financial consulting		15,448						
McKee Environmental	Inspections		2,575						
Legal adj to Zero			9,160						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 333,155	TOTAL			\$		

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12/01/14

Ending:

11/30/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$6,360
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 57,488
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,196
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Michael J Feriozzi CPA
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NA
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH	4,564,609				1,009	1,009 CASH 4,564,609
1010	CASH IN BANK					1,100	1,100 ACCTS R 1,226,003
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW (540,000)
1100	ACCOUNTS RECEIVABLE	686,003				1,110	1,110 ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 21,370
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	21,370				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 0
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 1,451,481
1409	LAND	0				1,460	1,460 0
1450	FURNITURE & EQUIPMENT	1,451,481				1,475	1,475 BUILDIN 4,492,572
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM1 (4,360,067)
1475	BUILDING & IMPROVEMEN	4,492,572				1,530	1,530 RESIDEN 17,758
1490	ACCUM DEPR-BUILDING	-4,360,067				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	17,758				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 A/R REL 578,689
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (496,805)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	578,689				2,100	2,100 ACCRUE (172,282)
2010	ACCOUNTS PAYABLE	-496,805				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-172,282				2,110	2,110 ACCRUE (178,239)
2110	ACCRUED VACATION PAY	-178,239				2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(12,466)	
2125	FICA TAX PAYABLE	-12,466	-12,466	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE REF		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETE		
2240	UNITED WAY			2,246	2,250 401K W/F		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE G.		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	(21,188)	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(39,642)	
2300	ACCRUED INTEREST PAYABLE			2,350	2,350 REAL ES	0	
2310	ACCRUED EXPENSES	-21,188		2,385		0	
2320	IPA PAYMENTS PAYABLE	-39,642		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO 1	(17,758)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	0	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEB		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED	(6,543,336)	
2460	INCOME TAXES PAYABLE				net income	29,301	
2512	DUE TO RESIDENTS	-17,758					
2600	MORTGAGE PAYABLE	0			balance	<u>0</u>	
2650	EQUIPMENT LOAN PAYABLE						
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-6,543,336					
2970	PROFIT/LOSS FOR PERIOD	29,301					
3007.1	PATIENT DAYS-PRIVATE	14,100					3,007

3007.2	PATIENT DAYS-IPA	14,383						3,007
3007.3	PATIENT DAYS-MEDICARE	3,133						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-5,815,870	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-30,240	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-259,283	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,196,316	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,075,208	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	0		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-639		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-8,170		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	-4,147		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	309,371	346,261	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	93,068	93,068	17	1	0	0		4,120
4115	VACATION & SICK - G&A	36,890		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	252,416	751,835	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP	0		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	69,823	69,823	21	2	0	0		4,275
4260	TELEPHONE	11,886	11,886	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	200	200	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	8,160	9,613	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	1,453		24	3	19	-4,614 ***		4,289
4290	HELP WANTED ADVERTISING	3,340	98,724	20	3	0	0 -57,488		4,290
4291	PROMOTIONAL ADVERTISING	23,693		20	3	25	-23,693		4,291
4292	PUBLIC RELATIONS	3,293		20	3	25	-3,293		4,292
4300	LICENSES & FEES	58,850		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	6,726		20	3	17	0		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	55,478	333,155	19	3	22	-9,160		4,350
4355	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSI	2,970		10	3	0	0	4,364
4363	PHARMACIST FEES	3,426		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,794	3,794	12	3	0	0	4,383
4370	TV RENTAL	3,878		35	3	5	0	4,390
4380	INCOME TAXES		0	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,822		20	3	26	0	4,401
4400	PAYROLL TAXES	230,956		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,159		22	3	0	0	4,420
4410	GROUP INSURANCE	118,427		22	3	0	0	4,430
4420	LIABILITY INSURANCE	82,990	82,990	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	141,877		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	277,677		19	3	34	0 **	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	3,828	7,706	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	76,383	83,785	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	7,402		6	1	0	0	4,510
5130	ELECTRIC	73,375	134,284	5	3	0	0	4,600
5131	NATURAL GAS	20,130		5	3	0	0	5,110
5132	HEATING & DIESEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	40,779		5	3	0	0	5,130
5134	TRASH COLLECTION	13,705	47,345	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	0	87,072	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	87,072		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	33,640		6	3	0	0	5,140
5210	DIETARY WAGES	230,257	245,573	1	1	0	0	5,160
5220	DIETARY SICK & VAC	15,316		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	246,297	228,097	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	1,024	20,261	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	455		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	18,782		1	2	0	0	5,260
5295	MEAL CREDIT	-18,200		2	2	0	0	5,270
5310	LAUNDRY WAGES	7,757	7,899	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	142		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	10,934	14,362	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	3,428		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	213,674	229,355	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	15,681		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	44,813	45,747	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	934		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		2,038,170	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	187,536		10	1	0	0	6,020
6030	DON WAGES	73,654		10	1	0	0	6,030
6035	ADON	36,533		10	1	0	0	6,035
6040	RN SICK & VACATION	19,489		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	663,109		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	40,594		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	958,423		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	58,832		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	5,943	5,943	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	860	860	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	0		10	1	0	0	6,390
6275	REHAB SICK & VAC	0		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	20,970	175,820	10	2	0	0	7,281
6295	NURSING SUPPLIES	154,850		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	0		10	2	0	0	7,391
6490	NURSING OTHER	2,302	8,698	10	3	0	0	7,393
7280	DRUG PURCHASES	171,830	171,830	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	0		39	2			7,540
7380	LABORATORY SERVICES	37,364	709,577	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	92,293	98,812	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	6,519		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	9,005	9,005	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	329,740		39	3	0	0 ***	7,890
7660	PT SUPPLIES	0		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	22,787	24,147	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,360		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	304,140		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	38,333		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	0	0	32	3	14	-11,102	
8130	DEPRECIATION	187,163	187,163	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-11,102		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	-115,000		0	0	0	0	
		6,268,758	6,394,860					
			126,102					

GRAND TOTALS 29,301 -51,862
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

PP 14,100
IPA 14,383
medicare 3,133

RECAP CENSUS

14,100
14,383
3,133
31,616

UND

RIA

BT

BT

3,007 PATIENT	14,383
3,007 PATIENT	3,133
	0

3,010 BASIC CI	(5,815,870)
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3,020 BASIC CI	0
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3,030 BASIC CI	0
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	0
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3,080 NURSING	(30,240)
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3,081 NURSING	0
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3,082 NURSING	0
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3,083 NURSING	0
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3,100 DRUGS-M	(259,283)
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	0
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3,110 PHYSICIAN	(2,196,316)
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	0
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3,112 PHYSICIAN	0
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3,113 PHYSICIAN	0
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3,140 LABORATORY INCOME	
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	0
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3,152 ST/OT TR	0
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3,153 ST/OT TR	0
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3,185 REHABILITATION/ISOLATION/OTHER CHG	
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3,410 IPA/OTHER	0
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3,411 MEDICAL	0
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3,420 MEDICAL	1,951,968
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3,520 RENT INC	0
3,530 BEAUTY	0
	0
3,570 VENDING	(639)
3,590 EQUIPMI	(8,170)
3,595 RESIDEN	0
3,600 MISC INC	(4,147)
4,110 G&A WA	309,371
4,111 ADMINIS	93,068
4,115 G&A PTC	36,890
4,120 EMPLOY	253,868
4,130 EMPLOY	0
4,135 EMPLOY	0
4,250 OFFICE S	15,945
4,255 POSTAGI	4,451
4,260 TELEPHC	11,886
4,275 TRAININ	200
	0
4,280 GENERA	8,160
4,281 MEAL EX	0
4,285 EDUCAT	1,453
4,289 MEETING	0
4,290 HELP WA	3,340
4,291 PROMOT	23,693
4,292 PUBLIC I	3,293
4,300 LICENSE	58,850
4,310 DUES & S	6,726
4,320 CONTRIE	0
4,350 PROFESS	55,478
4,355 MEDICAL	12,000
	2,970
	3,426

4,364 SOCIAL S	3,794
4,370 TV RENT	3,878
4,383 BACKGR	2,822
4,390 OTHER T	0
4,400 PAYROL	230,956
4,401 PAYROL	8,159
4,410 GROUP I	118,427
4,420 LIABILIT	82,990
4,430 WORKM.	141,877
4,435 W/C-FIRS	0
4,436 DRUG TE	0
4,450 MANAGI	277,677
4,460 BAD DEF	0
4,461 BAD DEF	123,240
4,470 LOST ITE	0
4,475 UNIFORM	(1,452)
4,486 SERVICE	20,961
4,490 MISC EX	1,296
4,496 MISC. M.	49,427
4,510 REAL ES	0
4,600 LEASED	3,828
5,110 MAINTEI	76,383
5,120 MAINTEI	7,402
5,130 ELECTRI	73,375
5,131 NATURA	20,130
5,133 WATER &	40,779
5,134 TRASH C	13,705
5,140 PROP/PL	0
5,160 GENERA	87,072
5,165 MAINTEI	12,679
5,210 DIETARY	230,257
5,220 DIETARY	15,316
5,248 FOOD PU	245,001

5,250 SUPPLIE	1,024
5,260 REPLACI	455
5,270 KITCHEN	18,782
5,295 MEAL IN	(18,200)
5,310 LAUNDR	7,757
5,340 LAUNDR	142
5,370 REPLACI	10,934
	0
5,390 SUPPLIE	3,428
5,410 HOUSEK	213,674
5,440 HOUSEK	15,681
5,480 SUPPLIE	44,813
5,490 SUPPLIE	934
6,020 RN WAG	187,536
6,030 DON WA	73,654
6,035 ADON W	36,533
6,040 RN PTO &	19,489
6,120 LPN WAG	663,109
6,140 LPN PTO	40,594
6,220 AIDES W	958,423
6,240 AIDES PT	58,832
	5,943
	860
	0
6,270 REHAB V	0
6,275 REHAB F	0
6,290 NURSINC	20,970
6,295 NURSINC	154,850
6,390 REPLACI	0
6,490 OTHER	2,302

7,280 DRUG PU	171,830
7,281 DRUG PU	0
7,380 LABORA	13,995
7,390 X-RAY S	23,369
	0
7,510 ACTIVIT	92,293
7,540 ACTIVIT	6,519
7,590 ACTIVIT	9,005
7,620 PHYSICA	329,740
7,660 P.T. SUPE	0
7,710 SOCIAL S	22,787
7,720 SOCIAL S	1,360
7,730 SOCIAL S	0
7,740 OCCUPA	304,140
7,770 SPEECH'	38,333
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	0
	0
8,130 DEPRECI	187,163
	0
9,510 INTERES	(11,102)
9,520 MISC NO	(115,000)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>29,301</u>

Expenses Fixed Assets

Sunny Acres Home of Menard County
HFS ID# 376005977001
HFS Cost Report - November 30, 2015
Schedule V - Column 5 Reclassifications

Lines 10a and 39

Cost of Drugs Purchased	\$171,830
Cost of Laboratory Services Purchased	\$13,995
Cost of X-Ray Services Purchased	\$11,867
Cost of Ambulance Services Purchased	<u>\$11,502</u>
Reclassification Amount	<u><u>\$209,194</u></u>

Lines 20 and 42

Provider Participation Fee (105*365*\$1.50)	<u><u>\$57,488</u></u>
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