SECTION I

FACILITY INFORMATION AND UTILIZATION DURING CALENDAR YEAR 2024

Please provide the following information for your long-term care facility:

Facility License Number	0014076
Facility Name	Sunny Hill Nursing Home of Will County
Facility Address	421 Doris Ave
Facility City	Joliet
Facility Zip Code	60433
Facility FEIN Number	36-6006672

Is your facility designated as a Life Care Facility or a Continuing Care Retirement Community? If so, please mark the applicable choice(s):

- [ ] Life Care Facility
- [ ] Continuing Care Retirement Community

If any of the conditions listed below will prevent a prospective patient from admission to your facility, please mark the applicable conditions:

- [x] Aggressive/Anti-Social Behavior
- [x] Chronic Alcoholism
- [x] Developmental Disability
- [x] Drug Addiction
- [ ] Medicaid Recipient
- [ ] Medicare Recipient
- [x] Mental Illness
- [ ] Patient Non-Ambulatory
- [ ] Patient Non-Mobile
- [ ] Government Payment Recipient
- [ ] Under 65 Years of Age
- [ ] Patient Unable to Self-Medicate
- [x] Patient Ventilator Dependent
- [ ] Infectious Disease Requiring Isolation
- [ ] Any other Admission Restriction
- [ ] None Applicable

If your facility ownership requires that the facility have a agent registered with the Illinois Secretary of State, indicate the name, address and telephone number of the Registered Agent:

Registered Agent Name

Registered Agent Street Address

Registered Agent City, State and Zip Code

Registered Agent Telephone Number

FACILITY STAFFING

Please report the number of Full-Time Equivalent (FTE) staff employed directly by your facility during the first pay period of December, 2024. DO NOT REPORT NUMBER OF HOURS WORKED. A Full-Time Equivalent of a staff member's employment is calculated by dividing the number of hours that person worked by the typical hours worked by a full-time staff member in that position. For example, if a staff member worked 16 hours in the pay period, and a full-time employee would typically work 40 hours, that staff person accounted for 0.4 Full-Time Equivalent (FTE).

Due to the wide range of services provided in long-term care facilities, we have included 2 aggregated employment categories: Other Healthcare Personnel, for health-related staff not listed separately, and Other Non-Health Personnel, for staff not directly involved in the provision of health care to patients.

EMPLOYMENT CATEGORIES	FULL-TIME EQUIVALENTS (FTEs)
Administrators	2.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	23.90
LPNs	16.40
Certified Aides	55.83
Other Healthcare Personnel	3.00
Other Non-Health Personnel	65.45
TOTALS	167.58

Please indicate the typical number of hours in a work week for a full-time employee: 40.00

FACILITY ADMISSIONS AND DISCHARGES DURING CALENDAR YEAR 2021

Please report the number of initial admissions to and final discharges from your facility during Calendar Year 2024.

Count only new admissions to and permanent discharges from the facility. Short-term discharges for Acute or Sub-Acute hospital care, or temporary releases to visit friends or relatives for patients expected to return to the facility are not to be counted as discharges and re-admissions. If a person has been discharged from care, but later in the year is re-admitted, please count both the discharge and the re-admission. The calculated number in the yellow box must equal the totals in the yellow boxes on the following pages.

Indicate the number of patients in your facility on January 1, 2024	142
Indicate the number of initial admissions to your facility during 2024	131
Indicate the number of permanent discharges from your facility during 2024	122
This number should be the number of patients in your facility on December 31, 2024	151

FACILITY UTILIZATION – BEDS, RESIDENTS, PATIENT DAYS
Patient Days of Care are TOTALS for care provided during Calendar Year 2024. Patient Information is for Patients in the facility on December 31, 2024.

BEDS	SKILLED/INTERMEDIATE NURSING CARE	SHELTERED CARE	TOTALS
Licensed Beds – 12/31/2024	157	0	157
Highest One-Day Beds Set Up	0	0	
Highest One-Day Beds Occupied	0	0	
Beds Set Up – 12/31/2024	157	0	157
Beds Occupied – 12/31/2024	151	0	151
TOTAL PATIENT DAYS OF CARE – CALENDAR YEAR 2024			
MEDICARE	4427		4,427
MEDICAID	33848		33,848
OTHER PUBLIC PROGRAM	0	0	0
PRIVATE INSURANCE	0	0	0
PRIVATE PAYMENT	15301	0	15,301
CHARITY CARE	0	0	0
TOTALS	53576	0	53,576
PATIENTS AS OF DECEMBER 31, 2024			
MALES – Under 18	0	0	0
18-44 Years Old	0	0	0
45-59 Years Old	0	0	0
60-64 Years Old	1	0	1
65-74 Years Old	2	0	2
75-84 Years Old	21	0	21
85 or more Years Old	14	0	14
MALE TOTALS	38	0	38
FEMALES – Under 18	0	0	0
18-44 Years Old	0	0	0
45-59 Years Old	0	0	0
60-64 Years Old	0	0	0
65-74 Years Old	12	0	12
75-84 Years Old	40	0	40
85 or more Years Old	61	0	61
FEMALE TOTALS	113	0	113
TOTAL RESIDENTS	151	0	151

	SKILLED/INTERMEDIATE NURSING CARE	SHELTERED CARE	TOTALS
PATIENTS BY RACIAL GROUP AS OF DECEMBER 31, 2024			
ASIAN	1	0	1
AMERICAN INDIAN	0	0	0
BLACK/AFR. AMERICAN	12	0	12
HAWAIIAN/PAC. ISL.	1	0	1
WHITE	137	0	137
RACE UNKNOWN	0	0	0
TOTALS	151	0	151
PATIENTS BY ETHNICITY AS OF DECEMBER 31, 2024			
HISPANIC/LATINO	7	0	7
NOT HISPANIC/LATINO	144	0	144
ETHNICITY UNKNOWN	0	0	0
TOTALS	151	0	151
PATIENTS BY PRIMARY PAYMENT SOURCE AS OF DECEMBER 31, 2024			
MEDICARE	9		9
MEDICAID	91		91
OTHER PUBLIC PROG.	0	0	0
PRIVATE INSURANCE	0	0	0
PRIVATE PAYMENT	51	0	51
CHARITY CARE	0	0	0
TOTALS	151	0	151
PRIVATE PAYMENT DAILY ROOM RATES AS OF DECEMBER 31, 2024			
PRIVATE ROOM	0	0	
SHARED ROOM	0	0	

RESIDENTS AS OF DECEMBER 31, 2020 BY PRIMARY DIAGNOSIS – ICD-10
Please list the number of patients in your facility on December 31, 2024, by the ICD-10 coding group of the primary diagnosis of the patient. Each patient should be counted once and only once.

ICD-10 CM Code Groups	Primary Diagnostic Group	Number of Residents
C00 - D49	Neoplasms	2
D50 - D69	Blood Disorders	1
E00 – E89	Endocrine/Metabolic Disorders	15
F01 – F69	Mental Illness	9
F70 – F99	Developmental Disabilities	0
G300 – G309	Alzheimer's Disease	5
G00 – G99	Nervous System Disorders (excluding Alzheimer's Disease)	26
I00 – I99	Circulatory System Disorders	52
J00 – J99	Respiratory System Disorders	12
K00 – K95	Digestive System Disorders	0
L00 – L99	Skin Disorders	3
M00 – M99	Musculo-Skeletal Disorders	13
N00 – N99	Genitourinary System Disorders	5
S00 – T88	Injuries and Poisonings	2
	Other Medical Conditions	3
	Non-Medical Conditions	0
	Total Residents on December 31, 2024	**148**
	Total Occupied Beds on December 31, 2024 (from page 4)	**151**

RESIDENTS AS OF DECEMBER 31, 2024, DIAGNOSED AS MENTALLY ILL
How many of your patients on December 31, 2024, had diagnoses including Mental Illness (ICD-10 codes F01 - F69)? 9

RESIDENTS AS OF DECEMBER 31, 2024, CATEGORIZED AS IDENTIFIED OFFENDERS
How many of your patients on December 31, 2024, had been identified by a Criminal Background Check, as required by the Nursing Home Care Act (210 ILCS 45/2-201.5 paragraphs b and c)? 0

SECTION II
Financial and Capital Expenditure information for your facility
for your Most Recent Available Fiscal Year

The information from this section will come from your Most Recent Annual Financial Statements, which include your Income Statement and Balance Sheet. Sources of Financial Data can be Audited Financial Statements, Review or Compilation Financial Statements, or Tax Return Documents for your Most Recent Fiscal Year.

Please indicate the Starting Date and Ending Date (format mm/dd/yyyy) for your Fiscal Year:

STARTING DATE 12/1/2023 ENDING DATE 11/30/2024

Please select the Data Source used for the information reported in this section:

Review or Compilation Financial Statements

CAPITAL EXPENDITURES
Capital expenditures are defined as "Any expenditure : (A) made by or on behalf of a health care facility …….and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part there of or any equipment for a facility or part… and includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made… and includes donations of equipment of facilities or a transfer of equipment or facilities at fair market value."

Please report the TOTAL CAPITAL EXPENDITURES DURING YOUR REPORTING YEAR: $0.00

Please provide the following information ONLY FOR PROJECTS/EXPENDITURES IN EXCESS OF $350,000 obligated by, or on behalf of, the facility during the reporting year.

Description of Project/Expenditure	Amount Obligated	Method of Financing	CON Project Number (if applicable)
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		

NET REVENUE BY PAYMENT SOURCE FOR REPORTED FISCAL YEAR
Please report the Net Revenue of the facility during the reported Fiscal Year by the listed sources of revenue:

Source of Payment*	Net Revenue (Dollars)
Medicare	$1,042,436.00
Medicaid	$2,856,937.00
Other Public Payment	$0.00
Private Insurance	$0.00
Private Payment	$0.00
TOTALS	**$3,899,373.00**

*OTHER PUBLIC PAYMENT includes payments from Veterans' Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, and other government-sponsored programs, excluding Medicare and Medicaid.

PRIVATE INSURANCE refers to payments made through private insurance policies.

PRIVATE PAYMENT includes money from a private account, such as a Medical Savings Account, and any government funding paid to the resident and then transferred to the facility in payment for services.

Revenue from Medicare-Medicaid Alignment Initiative (MMAI) should be included in Medicare.

Revenue from Medicaid Managed Care should be included in Medicaid.

ACTUAL COST OF SERVICES PROVIDED TO CHARITY CARE RECIPIENTS FOR THE REPORTED FISCAL YEAR
Please report the Actual Cost of Services provided by your facility to recipients of Charity Care* during the reported Fiscal Year.

	Amount (Dollars)
Actual Cost of Charity Care Services	$ 0.00

*Charity Care means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer [20 ILCS 3960, section 3]. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other Federal, State or local indigent health care programs, eligibility for which is based on financial need.

SECTION III

Patient and Staff Influenza and Pneumonia Immunization

The Immunization Section of the Illinois Department of Public Health requests that you provide the following information regarding immunization policies and the immunization status of facility staff and patients in regard to immunizations for influenza and pneumococcal pneumonia. Thank you.

	YES	NO
Does your facility have a written policy for administering influenza vaccine to your patients?	●	○
Does your facility have a written policy for administering pneumococcal vaccine to your patients?	●	○
Does your facility have a written policy for administering influenza vaccine to staff members?	●	○
Does your facility have a written policy for administering pneumococcal vaccine to staff members?	●	○
Does your facility have a written policy for the use of amantadine and/or rimantadine during an influenza outbreak?	○	●

	Number Receiving Vaccine	Number Not Receiving Vaccine	TOTALS
How many patients of your facility from October, 2024 through January, 2024, received an influenza vaccination?	126	26	152
How many of your patients as of December 31, 2024, had received a pneumococcal pneumonia vaccination during the period of 2017 through 2024?	117	36	153

Authorized Electronic Monitoring

Effective January 1, 2016, the Authorized Electronic Monitoring in Long-Term Care Facilities Act (210 ILCS 32/), Public Act 99-0430, set forth conditions and processes whereby a long-term care resident could request authroized electronic monitoring of his/her living quarters. As part of this Act, each long-term care facility covered by the Act must annually report to the Illinois Department of Public Health the number of requests the facility has received for electronic monitoring.

In order to reduce the number of separate data requests, the Office of Health Care Regulation of the Illinois Department of Public Health has requested that this reporting be incorporated into the HFSRB Annual Long-Term Care (LTC) Facility Questionnaire.

Please note that this information wll not be used in the Certificate of Need process. Should you have any questions regarding the Authorized Electronic Monitoring Act, please contact the IDPH Office of Health Care Regulation at 217/782-5180.

Thank you.

Authorized Electronic Monitoring	
How many Electronic Monitoring Notification and Consent Forms were submitted by facility residents in Calendar Year 2024?	0
How many of the above requests for electronic monitoring in Calendar Year 2024 were approved?	0
How many of the above requests for electronic monitoring in Calendar Year 2024 were denied?	0

Older Adult Services Provided by your facility

The Older Adult Services Advisory Committee, created by Public Act 093-1031, is required to gather information about services being provided to older adults in Illinois as part of its mandate to "promote a transformation of illinois' comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based delivery system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services."

Please indicate the average daily number of clients (not facility residents) served by your facility in the past month for the following services

Outpatient/Community-Based Services	Average Daily Clients Served in the Past Month
Outpatient Physical Therapy	0
Outpatient Occupational Therapy	0
Outpatient Speech Therapy	0
In-house Respite Care Program – 24 Hours or More	0
In-house Respite Care Program – Less than 24 Hours per Day	0
Adult Day Care Services – Not Respite Care Program	0
Alzheimer's Adult Day Care Services – Not Respite Care Program	0
Home Health Care for Medicare or Medicaid Clients	0
Home Care Services for Private Pay Clients	0
Homemakers and Personal Care Assistants	0
Home Delivered Meals Program	0
Transportation Services for Community Members	0
Outpatient Wound Care and/or Specialized Wound Care	0
Outpatient Dialysis	0
Community Family Caregiver Training or Support	0
Community Nutrition Site	0
Outpatient Telephone Reassurance for Community Seniors	0
Private Duty Nursing Services	0

If your facility offers other Outpatient/Community Services not listed above, please report them here:

CONTACT INFORMATION AND DATA CERTIFICATION

Please provide the following contact information for the administrator of this facility:

Administrator Name	Margaret McDowell
Administrator Job Title	Administrator
Administrator Telephone	815-727-8650
Administrator Email	mmcdowell@willcountyillinois.com

Please provide the following contact information for the individual responsible for completion of this form:

Contact Person Name	Margaret McDowell
Contact Person Job Title	Administrator
Contact Person Telephone	815-727-8650
Contact Person Email	mmcdowell@willcountyillinois.com

By entering your name, title and date for this certification, you agree to the following statement

CERTIFICATION OF DATA CONTAINED IN THIS FORM

Pursuant to the Health Facilities Planning Act [20 ILCS 3960/13], the State Board requires "all health facilities operating in the State of Illinois to provide such reasonable reports at such times and containing such information as is needed" by the Board to carry out the purposes and provisions of this Act. The individual named below certifies that he/she has reviewed this document, that he/she is authorized to make this certification on behalf of this facility, and that the information contained in this report is accurate, truthful and complete to the best of his/her knowledge and belief. Please note that the State Board will be relying on the information contained in this document as being truthful and accurate information. Any misrepresentation will be considered material.

☒ I certify that the information in this report is accurate, truthful and complete to the best of my knowledge.

Person Certifying (Type Name)	Margaret McDowell		
Job Title	Administrator	Certification Date (mm/dd/yyyy)	03/10/2025

If you have any comments regarding this survey or the information contained herein, please enter them below:

INSTRUCTIONS FOR SUBMITTING COMPLETED QUESTIONNAIRE

When you have completed this form and saved the completed form to your computer system, please attach the completed form to an Email and send to DPH.FacilitySurvey@illinois.gov

Please put "LTC Questionnaire" in the subject line.

Your completed questionnaire must be submitted by April 30, 2022.