FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0046821

Facility Name: Valley Hi Nursing Home

Address: 2406 Hartland Road (Number) Woodstock (City) 60098 (Zip Code)

County: McHenry

Telephone Number: (815) 338-0312 **Fax #** (815) 338-0458

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1956

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler **Telephone Number:** (847) 374-0400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2015 to 11/30/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 374-0400 Fax # (847) 374-0420

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

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,848	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	128	TOTALS	128	46,848	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,964	15,182	9,664	43,810	8
9	SNF/PED					9
10	ICF	146	149		295	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,110	15,331	9,664	44,105	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.14%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 1/1/1956

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 3,725

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	516,178	32,725	10,675	559,578		559,578		559,578			1
2	Food Purchase		440,964		440,964		440,964	(13,342)	427,622			2
3	Housekeeping	297,209	57,680	900	355,789		355,789		355,789			3
4	Laundry	179,270	46,181		225,451		225,451		225,451			4
5	Heat and Other Utilities			139,602	139,602		139,602		139,602			5
6	Maintenance	99,860	607	176,566	277,033		277,033	(84)	276,949			6
7	Other (specify):*											7
8	TOTAL General Services	1,092,517	578,157	327,743	1,998,417		1,998,417	(13,426)	1,984,991			8
	B. Health Care and Programs											
9	Medical Director			34,755	34,755		34,755		34,755			9
10	Nursing and Medical Records	3,365,576	293,093	76,535	3,735,204		3,735,204	(8,719)	3,726,485			10
10a	Therapy	81,906	2,157		84,063		84,063		84,063			10a
11	Activities	171,216	14,590	4,413	190,219		190,219		190,219			11
12	Social Services	216,154		3,726	219,880		219,880		219,880			12
13	CNA Training											13
14	Program Transportation			674	674		674		674			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,834,852	309,840	120,103	4,264,795		4,264,795	(8,719)	4,256,076			16
	C. General Administration											
17	Administrative	180,093			180,093		180,093		180,093			17
18	Directors Fees											18
19	Professional Services			31,898	31,898		31,898		31,898			19
20	Dues, Fees, Subscriptions & Promotions			28,671	28,671		28,671	(3,337)	25,334			20
21	Clerical & General Office Expenses	292,830	10,677	184,380	487,887		487,887	(84,471)	403,416			21
22	Employee Benefits & Payroll Taxes			2,858,072	2,858,072		2,858,072		2,858,072			22
23	Inservice Training & Education			800	800		800		800			23
24	Travel and Seminar			18,068	18,068		18,068	(750)	17,318			24
25	Other Admin. Staff Transportation			7,021	7,021		7,021	(602)	6,419			25
26	Insurance-Prop.Liab.Malpractice			306,833	306,833		306,833		306,833			26
27	Other (specify):*											27
28	TOTAL General Administration	472,923	10,677	3,435,743	3,919,343		3,919,343	(89,160)	3,830,183			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,400,292	898,674	3,883,589	10,182,555		10,182,555	(111,305)	10,071,250			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Valley Hi Nursing Home
0046821
Supplemental Travel Schedule
12/1/2015-11/30/2016

JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILEAGE	FOOD	Train/Cab Tolls/Park	HOTEL	TOTAL	
Admissions	Mchenry, IL	NIMC for pre resident eval	32.62				32.62	
Admissions	Mchenry, IL	Alden Terrace for pre resident eval	14.15				14.15	
Nurse Liason	Woodstock, IL	Dr Arora's Office for Medical Records					0.00	
Administrator	Springfield, IL	IHCA Board of Directors Meeting	933.73		17.25		950.98	
Administrator	Springfield, IL	IL Leaders Program Kick off Meeting				91.84	91.84	
Business Office	Lombard, IL	MatrixCare Software Training	33.59				33.59	
Business Office	Lombard, IL	MatrixCare Software Training	55.42				55.42	
Administrator	Springfield, IL	IHCA Public Policy Forum	229.93		7.00	155.68	392.61	
Business Office	Wheaton, IL	Medicaid Electronic Billing Seminar	50.22				50.22	
Administrator	Woodstock, IL	Event w/Op Board & Mgmt Staff		89.24			89.24	
Administrator	Woodstock, IL	TN			300.97	301.25	602.22	ADJ
Social Services	Downers Grove, IL	Seminar	58.43				58.43	
Administrator	Peoria, IL	IHCA Annual Convention	183.60				183.60	
Asst Administrator	Springfield, IL	APIC EPI 101 for Longterm Care	241.38				241.38	
Administrator	Woodstock, IL	Meeting		30.93			30.93	
Administrator	Peoria, IL	IHCA Annual Convention				680.80	680.80	
Asst Administrator	Springfield, IL	Longterm Care				152.88	152.88	
Administrator	Springfield, IL	IHCA IL Leaders Convention				150.08	150.08	
							0.00	
			1,833.07	**120.17**	**325.22**	**1,532.53**	**3,810.99**	
		TOTAL FOR ADMIN ACCT #'s	**610010-5040-10**	**610010-5050-10**	**0010-5050-**	**0010-5050-20**		
Dietary	Peoria, IL	IHCA Annual Convention	160.38	10.00		170.20	340.58	
			160.38	**10.00**	**0.00**	**170.20**	**340.58**	
		#'s	**610040-5040-10**	**610040-5050-10**	**0040-5050-**	**0040-5050-20**		
DON	Woodridge, IL	Dimentia Beyond Drugs Seminar	100.28				100.28	
DON	Milwaukee, WI	Direct Supply Tour	81.32				81.32	
DON	Lombard, IL	MatrixCare Software Training	68.09				68.09	
DON	Springfield, IL	IHCA Public Policy Forum	230.26		7.00	211.68	448.94	
DON	Peoria, IL	IHCA Annual Convention		21.28		255.30	276.58	
ADON	Peoria, IL	IHCA Annual Convention	180.36	10.00		340.40	530.76	
DON	Springfield, IL	APIC EPI 101 for Longterm Care	229.50	36.89	20.00	152.88	439.27	
DON	Springfield, IL	Care	235.44	39.29	14.00	266.56	555.29	
ADON	Rockford, IL	Rasmussen Job Fair	33.32				33.32	
							0.00	
			1,158.57	**107.46**	**41.00**	**1,226.82**	**2,533.85**	
		#'s	**610050-5040-10**	**610050-5050-10**	**0050-5050-**	**0050-5050-20**		
Activities	Woodstock, IL	Resident dinner	6.70				6.70	
Activities	Woodstock, IL	Resident dinner	14.10				14.10	
Activities	Woodstock, IL	Resident dinner	14.10				14.10	
Activities	Peoria, IL	IHCA Annual Convention		30.00		255.30	285.30	
Activities	Woodstock, IL	in Care Conf			15.50		15.50	
							0.00	
			34.90	**30.00**	**15.50**	**255.30**	**335.70**	
		#'s	**610070-5040-10**	**610070-5050-10**	**0070-5050-**	**0070-5050-20**		

Facility Name & ID Number Valley Hi Nursing Home #0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			539,901	539,901		539,901		539,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,418	32,418		32,418		32,418			35
36	Other (specify):*											36
37	**TOTAL Ownership**			572,319	572,319		572,319		572,319			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,064	664,107	808,171		808,171		808,171			39
40	Barber and Beauty Shops		853		853		853		853			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				315,500		315,500	(958)	314,542			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		144,917	664,107	1,124,524		1,124,524	(958)	1,123,566			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,400,292	1,043,591	5,120,015	11,879,398		11,879,398	(112,263)	11,767,135			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 Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,342)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,088)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,337)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(130,711)	21		24
25	Fund Raising, Advertising and Promotional	(4,582)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,060)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (160,060)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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

Valley Hi Nursing Home

ID# 0046821

Report Period Beginning: 12/1/2015

Ending: 11/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Polling Place Revenue	$ (75)	21	1
2	Medical Records Revenue	(650)	10	2
3	Scrap Revenue	(84)	6	3
4	Offset Rebate Medical	(8,069)	10	4
5	Provider Assesment Fee Adjustment	(958)	42	5
6	Out of State Travel	(602)	25	6
7	out of State Seminar	(750)	24	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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**	(11,188)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Valley Hi Nursing Home # 0046821 **Report Period Beginning:** 12/1/2015 **Ending:** 11/30/2016

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,342)	0	0	0	0	0	0	0	0	0	0	(13,342)	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	(84)	0	0	0	0	0	0	0	0	0	0	(84)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,426)	0	0	0	0	0	0	0	0	0	0	(13,426)	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	(8,719)	0	0	0	0	0	0	0	0	0	0	(8,719)	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**	(8,719)	0	0	0	0	0	0	0	0	0	0	(8,719)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,337)	0	0	0	0	0	0	0	0	0	0	(3,337)	20
21	Clerical & General Office Expenses	(143,456)	58,985	0	0	0	0	0	0	0	0	0	(84,471)	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	(750)	0	0	0	0	0	0	0	0	0	0	(750)	24
25	Other Admin. Staff Transportation	(602)	0	0	0	0	0	0	0	0	0	0	(602)	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**	(148,145)	58,985	0	0	0	0	0	0	0	0	0	(89,160)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(170,290)	58,985	0	0	0	0	0	0	0	0	0	(111,305)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Valley Hi Nursing Home # 0046821 **Report Period Beginning:** 12/1/2015 **Ending:** 11/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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	(958)	0	0	0	0	0	0	0	0	0	0	(958)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(958)	0	0	0	0	0	0	0	0	0	0	(958)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(171,248)	58,985	0	0	0	0	0	0	0	0	0	(112,263)	45

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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
See Page 6 Supplemental		None		See Page 6 - Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Computers	$	McHenry County	100.00%	$ 50,443	$ 50,443	1
2	V	21	Office		McHenry County	100.00%	8,542	8,542	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			$			$ 58,985	$ * 58,985	14

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

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	Yvonne Barnes	BOD			McHenry County	Woodstock	County Govt.	1
2	Andrew Gasser	BOD						2
3	Thomas Wilbeck	BOD						3
4	Robert "Bob" Nowak	BOD						4
5	James L. Heisler	BOD						5
6	Jeffrey Thorsen	BOD						6
7	Donna Kurtz	BOD						7
8	John Reinert	BOD						8
9	Joseph Gottemoller	BOD						9
10	Donald C. Kopsell	BOD						10
11	Chris Christensen	BOD						11
12	Michael J. Walkup	BOD						12
13	Kay R. Bates	BOD						13
14	John D. Hammerand	BOD						14
15	Craig Wilcox	BOD						15
16	Charles "Chuck" Wheeler	BOD						16
17	Paula Yensen	BOD						17
18	John Jung, Jr.	BOD						18
19	Michael Skala	BOD						19
20	Michael Rein	BOD						20
21	Michele Avang	BOD						21
22	Jim Kearns	BOD						22
23	Mary T. McCann	BOD						23
24	Larry W. Smith	BOD						24
25	Jack D. Franks	BOD						25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											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 Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 1/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: McHenry County Government Center
Street Address: 2200 North Seminary Avenue
City / State / Zip Code: Woodstock, IL 60098
Phone Number: (815) 334-4000
Fax Number: (815) 338-3991

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Data Available from McHenry				$	$		$	1
2		County Upon Request								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 Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

County Operated Entity does not pay real estate tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Valley Hi Nursing Home COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0046821

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,754 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	435,600	1884	$ 6,000	1
2					2
3	TOTALS	435,600		$ 6,000	3

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	12		2006	2006	$ 13,881,312	$	40	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	15,629		20				9
10	Various			1989	400,744		20				10
11	Various			1994	21,235		20				11
12	Various			1996	695,585		20				12
13	Various			2006	25,425		20				13
14	Various			2007	19,483		20				14
15	Various			2008	80,862		20				15
16	Various			2009	3,751		20				16
17	Various			2010	120,395		20				17
18	Various			2011	92,299		20				18
19	Various			2012	28,004		20				19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Architecht Svcs for Smoke Wall Remedial Repair	2013	$ 3,723	$	20	$	$	$	37
38	Sidewalks - Concrete Leveling and Caulking	2013	11,504		20				38
39	Pond Irrigation Wiring	2013	4,107		20				39
40	Pond Irrigation Compressor	2013	3,500		20				40
41	Replaced Preaction Panel in Fire Alarm System	2013	2,631		20				41
42	Replaced Seven Iam's and one Riam in Fire System	2013	2,882		20				42
43	16 Additional Locks Master Rekeyed	2014	2,563		20				43
44	Master Rekey of Nursing Home	2014	5,214		20				44
45	IP Cameras (4) Additional	2014	7,552		20				45
46	Fiberglass 35,190 Underground	2014	24,000		20				46
47	Fiberglass 35,190 Gallon Underground	2014	24,000		20				47
48	Dock Door Frame	2015	2,530		20				48
49	DCEO Energy Efficiency Program	2015	210,063		20				49
50	Architect: Flooring Nurses Stations/ Halls	2016	13,600		10				50
51	Flooring Laminate: Nurses Stations/ Halls	2016	168,599		10				51
52	Sealcoat, Repair and re-stripe parking lot	2016	37,061		10				52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Total Depreciation - Valley Hi Nursing Home			539,901		539,901		5,974,258	69
70	TOTAL (lines 4 thru 69)		$ 15,908,253	$ 539,901		$ 539,901	$	$ 5,974,258	70

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

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	$ 1,245,126	$	$	$	10	$	71
72	Current Year Purchases	421,884				10		72
73	Fully Depreciated Assets							73
74	Disposals	(221,772)						74
75	TOTALS	$ 1,445,238	$	$	$		$	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		1999 Ford Bus	1999	$ 40,035	$	$	$	5	$	76
77		2011 Chevy Equinox Car	2011	20,445				5		77
78		Tractor	1985	10,684				5		78
79										79
80	TOTALS			$ 71,164	$	$	$		$	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)	$ 17,430,655	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 539,901	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 539,901	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)	$ 5,974,258	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 Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 32,418 Description: See Attached
(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.

Valley Hi Nursing Home
0046821
12/1/2015- 11/30/2016

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Description	Amount
Photo Copier	11,465
Dish Machine	2,400
Bladder Scanner	250
Water Coolers	119
Tents for Resident Picnic	2,676
Tables for Resident Picnic	418
Chairs for Resident Picnic	270
Cotton Candy Machine	93
Hand Washing stations for Resident Picnic	100
Avaya Telephone Equipment	14,627
	32,418

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 268,828	$		$ 268,828	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			127,989			127,989	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			267,290			267,290	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				105,277		105,277	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached	39-2					38,787		38,787	13
14	TOTAL			$		$ 664,107	$ 144,064		$ 808,171	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.

Special Services - Supplies (Line 12-Column 6 - Other)	Amount
Lab-Medicare	9,679
X-Rays Medicare Part A	5,093
Rental of Medical Equipment	22,638
Medical Services - Outpatient Pt. A	1,377
Total	38,787

Facility Name & ID Number Valley Hi Nursing Home **#** 0046821 **Report Period Beginning:** 12/1/2015 **Ending:** 11/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/2016 **(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	$ 41,072,477	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (275,000))	4,536,728		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	25,805		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	863,249		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 46,498,259	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,000		13
14	Buildings, at Historical Cost	14,561,440		14
15	Leasehold Improvements, at Historical Cost	1,260,730		15
16	Equipment, at Historical Cost	2,058,122		16
17	Accumulated Depreciation (book methods)	(5,974,258)		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)**	$ 11,912,034	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 58,410,293	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 228,344	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,157,049		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	870,539		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,255,932	$	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)**	$ 4,255,932	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 53,950,920	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 58,206,852	$	48

***(See instructions.)**

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Line #	Other Current Assets:	Amount	Amount
9	Interest Receivable	73,653	
9	DOR- Pensions(GASB 68)	779,596	
9	Property Tax Receivable	10000	
	Total Line 9	863,249	

Line #	Other Non-Current Assets:	Amount	Amount
23			
	Total Line 23		

Line #	Other Non-Current Assets:	Amount	Amount
36	Bed Tax Liability	111,624	
36	Due to HFS	243	
36	Due to General Fund	477	
36	Due to Employee Benefit Fund	115,826	
36	Due to Other Cnty. Depts.	203,631	
36	OPEB Liability	428,738	
36	Deferred Property Tax Revenue	10,000	
	Total Line 36	870,539	

Line #	Other Non-Current Assets:	Amount	Amount
43			
	Total Line 43		

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 55,307,257	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4	**Restatement of Beginning FB - Chg. In Acctg Principle**	(203,441)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 55,103,818	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,152,898)	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)**	$ (1,152,898)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 53,950,920	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,395,471	1
2	Discounts and Allowances for all Levels	(2,319,118)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,076,353	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,186,714	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,186,714	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	13,342	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,303	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,903	19
20	Radiology and X-Ray	2,770	20
21	Other Medical Services	730	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 116,048	23
	D. Non-Operating Revenue		
24	Contributions	131	24
25	Interest and Other Investment Income***	337,762	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 337,893	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc. Income Adj. P. 5	9,492	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,492	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,726,500	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,998,417	31
32	Health Care	4,264,795	32
33	General Administration	3,919,343	33
	B. Capital Expense		
34	Ownership	572,319	34
	C. Ancillary Expense		
35	Special Cost Centers	809,024	35
36	Provider Participation Fee	315,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,879,398	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,152,898)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,152,898)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,861,374	44
45	Private Pay - Net Inpatient Revenue	3,280,573	45
46	Medicare - Net Inpatient Revenue	928,910	46
47	Other-(specify) Insurance	35,816	47
48	Other-(specify) Hospice	969,680	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,076,353	49

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

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

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

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

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,816	2,080	$ 82,811	$ 39.81	1
2	Assistant Director of Nursing	2,566	3,134	103,689	33.09	2
3	Registered Nurses	33,238	37,338	1,137,571	30.47	3
4	Licensed Practical Nurses	16,991	19,726	508,060	25.76	4
5	CNAs & Orderlies	88,398	99,277	1,359,801	13.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,275	4,387	81,906	18.67	8
9	Activity Director	1,980	2,218	47,930	21.61	9
10	Activity Assistants	9,605	10,957	123,286	11.25	10
11	Social Service Workers	7,403	8,481	216,154	25.49	11
12	Dietician					12
13	Food Service Supervisor	4,755	5,294	101,593	19.19	13
14	Head Cook	4,115	4,733	66,113	13.97	14
15	Cook Helpers/Assistants	5,572	6,644	90,280	13.59	15
16	Dishwashers	20,118	23,038	258,192	11.21	16
17	Maintenance Workers	3,291	3,843	99,860	25.98	17
18	Housekeepers	20,400	23,750	297,209	12.51	18
19	Laundry	11,825	13,374	179,270	13.40	19
20	Administrator	1,920	2,080	111,358	53.54	20
21	Assistant Administrator	1,896	2,080	68,735	33.05	21
22	Other Administrative	5,836	7,032	192,731	27.41	22
23	Office Manager					23
24	Clerical	6,373	7,022	100,099	14.26	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	1,679	1,960	44,866	22.89	31
32	Other Health Care(specify)					32
33	Other(specify) Supply/Unit Clerk	8,156	9,245	128,778	13.93	33
34	TOTAL (lines 1 - 33)	261,208	297,693	$ 5,400,292 *	$ 18.14	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	224	$ 10,675	1-3	35
36	Medical Director	Monthly	34,755	9-3	36
37	Medical Records Consultant	7	494	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,536	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	4,413	11-3	44
45	Social Service Consultant	49	3,726	12-3	45
46	Other(specify)				46
47	Dermatology Consultant	6	1,500	10-3	47
48					48
49	TOTAL (lines 35 - 48)	346	$ 57,099		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	232	$ 10,575	10-3	50
51	Licensed Practical Nurses	289	13,415	10-3	51
52	Certified Nurse Assistants/Aides	585	14,395	10-3	52
53	TOTAL (lines 50 - 52)	1,106	$ 38,385		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Annarella	Administrator	0%	$ 111,358
Tara Goosens	Asst. Admin	0%	68,735
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 180,093

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Baker Tilly Virchow Kraus	Audit	$ 7,100
FGMK, LLC	Cost Report/Consulting	9,019
Episode Alert	Medicare Software	779
WIPFLI, LLP	Market Study Project	15,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 31,898

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	413,621
Employee Health Insurance	1,401,082
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	504,701
Employee Physicals	8,056
Pension Expense	529,284
Employee Relations	469
Sick Leave Buy-Back	859
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,858,072

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	6,965
Health Care Worker Background Check	
(Indicate # of checks performed 27)	906
Patient Background Checks 66	660
Subscriptions	680
Publications	379
Licenses & Permits	450
Dues	11,256
Legal Notice Bid-Notice/Non-Disc.	58
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,334

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	18,068
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,068

* Attach copy of IMRF notifications

**See instructions.

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DATE	G/L ACCT#	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
3/3/2016	610010-4006-10	First National Bank of Omaha	2016 IHCA Public Policy Forum	Tom Annarella	Administrator	Springfield, IL	50	
4/26/2016	610010-4006-10	First National Bank of Omaha	AHCA Annual Convention - Nashville TN	Tom Annarella	Administrator	Nashville, TN	750	ADJ
6/9/2016	610010-4006-10	First National Bank of Omaha	Texts Posts & Tweets Web Seminar	Tara Goossens	Asst. Administrator	Woodstock, IL	60	
11/9/2016	610010-4006-10	Deborah Huml	Mindful Based Stress Reduction Seminar	Deborah Huml	Social Services	Downers Grove, IL	389.99	
9/15/2016	610010-4006-10	First National Bank of Omaha	IHCA Convention	Tom Annarella	Administrator	Springfield, IL	159	
12/1/2015	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tom Annarella	Administrator	Woodstock, IL	250	
12/1/2015	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tara Goossens	Asst. Administrator	Woodstock, IL	250	
12/1/2015	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tammy Schultz	HR/Payroll	Woodstock, IL	250	
12/1/2015	610010-4006-30	Durham Group	Executive Coaching and Team Development	Deborah Huml	Social Services	Woodstock, IL	250	
12/1/2015	610010-4006-30	Durham Group	Executive Coaching and Team Development	Sharon Chewning	Nurse Liason	Woodstock, IL	250	
2/15/2016	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tom Annarella	Administrator	Woodstock, IL	250	
2/15/2016	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tara Goossens	Asst. Administrator	Woodstock, IL	250	
2/15/2016	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tammy Schultz	HR/Payroll	Woodstock, IL	250	
2/15/2016	610010-4006-30	Durham Group	Executive Coaching and Team Development	Deborah Huml	Social Services	Woodstock, IL	250	
2/15/2016	610010-4006-30	Durham Group	Executive Coaching and Team Development	Sharon Chewning	Nurse Liason	Woodstock, IL	250	
7/31/2016	610010-4006-30	Durham Group	Executive Coaching and Team Development - Annual Fee	Tom Annarella	Administrator	Woodstock, IL	1666.65	
				Tara Goossens	Asst. Administrator			
				Tammy Schultz	HR/Payroll			
				Deborah Huml	Social Services			
				Sharon Chewning	Nurse Liason			
11/10/2016	610010-4006-30	First National Bank of Omaha	IHCA Req of Participation: Phase 1 - Webinar	Tom Annarella	Administrator	Woodstock, IL	75	
7/31/2016	610020-4006-30	Durham Group	Executive Coaching and Team Development - Annual Fee	Charles Martens	Laundry	Woodstock, IL	166.68	
7/31/2016	610030-4006-30	Durham Group	Executive Coaching and Team Development - Annual Fee	Charles Martens	Housekeeping	Woodstock, IL	166.69	
12/1/2015	610040-4006-30	Durham Group	Executive Coaching and Team Development	Pauletter Washay	Dietary	Woodstock, IL	250	
12/1/2015	610040-4006-30	Durham Group	Executive Coaching and Team Development	Patrick Jansen	Dietary	Woodstock, IL	250	
2/15/2016	610040-4006-30	Durham Group	Executive Coaching and Team Development	Pauletter Washay	Dietary	Woodstock, IL	250	
2/15/2016	610040-4006-30	Durham Group	Executive Coaching and Team Development	Patrick Jansen	Dietary	Woodstock, IL	250	
7/31/2016	610040-4006-30	Durham Group	Executive Coaching and Team Development - Annual Fee	Pauletter Washay	Dietary	Woodstock, IL	333.33	
7/31/2016	610040-4006-30	Durham Group	Executive Coaching and Team Development - Annual Fee	Patrick Jansen	Dietary	Woodstock, IL	333.33	
9/15/2016	610040-4006-10	First National Bank of Omaha	IHCA Convention	Paulette Washay	Dietary Director	Springfield, IL	159	
2/3/2016	610050-4006-10	First National Bank of Omaha	Infectious Disease	Meghan Judson	ADON	Woodstock, IL	40	
2/3/2016	610050-4006-10	First National Bank of Omaha	Infectious Disease	Dawn Redner	DON	Woodstock, IL	40	
4/13/2016	610050-4006-10	First National Bank of Omaha	2016 IHCA Public Policy Forum	Dawn Redner	DON	Springfield, IL	25	
9/15/2016	610050-4006-10	First National Bank of Omaha	IHCA Convention	Dawn Redner	DON	Springfield, IL	189	
9/15/2016	610050-4006-10	First National Bank of Omaha	IHCA Convention	Heather Harmon	ADON	Springfield, IL	189	
12/1/2015	610050-4006-30	Durham Group	Executive Coaching and Team Development	Dawn Redner	DON	Woodstock, IL	250	
12/1/2015	610050-4006-30	Durham Group	Executive Coaching and Team Development	Meghan Judson	ADON	Woodstock, IL	250	
12/1/2015	610050-4006-30	Durham Group	Executive Coaching and Team Development	Heather Harmon	ADON	Woodstock, IL	250	
2/15/2016	610050-4006-30	Durham Group	Executive Coaching and Team Development	Dawn Redner	DON	Woodstock, IL	250	
2/15/2016	610050-4006-30	Durham Group	Executive Coaching and Team Development	Meghan Judson	ADON	Woodstock, IL	250	
2/15/2016	610050-4006-30	Durham Group	Executive Coaching and Team Development	Heather Harmon	ADON	Woodstock, IL	250	
11/7/2016	610050-4006-30	Cristina Murray	CPR Training/Certification - 7 Attendees	Nursing Staff	Nursing	Woodstock, IL	140	
11/15/2016	610050-4006-30	Cristina Murray	CPR Training/Certification - 7 Attendees	Nursing Staff	Nursing	Woodstock, IL	140	
7/31/2016	610050-4006-30	Durham Group	Executive Coaching and Team Development - Annual Fee	Dawn Redner	DON	Woodstock, IL	999.99	
				Meghan Judson	ADON			
				Heather Harmon	ADON			
11/22/2016	610050-4006-30	First National Bank of Omaha	HIN: SNF PPS FY2017 Final Rule - Webinar	Nursing Staff	Nursing	Woodstock, IL	129	
6/24/2016	610070-4006-10	First National Bank of Omaha	Northern IL Activity Professionals - Making a Difference	Jennifer Palek	Activities	Dekalb, IL	40	
9/15/2016	610070-4006-10	First National Bank of Omaha	IHCA Convention	Linda Barrett	Activities	Springfield, IL	159	
12/1/2015	610070-4006-30	Durham Group	Executive Coaching and Team Development	Linda Barrett	Activities	Woodstock, IL	250	
2/15/2016	610070-4006-30	Durham Group	Executive Coaching and Team Development	Linda Barrett	Activities	Woodstock, IL	250	
11/7/2016	610070-4006-30	Cristina Murray	CPR Training/Certification - 2 Attendees	Activities Staff	Activities	Woodstock, IL	40	
11/15/2016	610070-4006-30	Cristina Murray	CPR Training/Certification - 2 Attendees	Activities Staff	Activities	Woodstock, IL	40	
7/31/2016	610070-4006-30	Durham Group	Executive Coaching and Team Development - Annual Fee	Linda Barrett	Activities	Woodstock, IL	333.33	
1/1/2016	610090-4006-30	CE Solutions	Infection Control,Bloodborn Pathogens Tuberculosis, Critical Thinkin	All Staff, All Staff,	All Staff	Woodstock, IL	5752.5	
2/1/2016	610090-4006-30	CE Solutions	The Long Term Care Survey and How to Survive It,	All Staff, All Staff, Nursin	All Staff	Woodstock, IL		
4/1/2016	610090-4006-30	CE Solutions	Alzheimer's Disease,	All Staff, All Staff,	All Staff	Woodstock, IL		
5/1/2016	610090-4006-30	CE Solutions	Back Safety,	All Staff, All Staff,	All Staff	Woodstock, IL		
5/4/2016	610090-4006-30	CE Solutions	Annual Payment for 1 year of online classes for Valley Hi Staff	All Staff	All Staff	Woodstock, IL		
7/1/2016	610090-4006-30	CE Solutions	Dealing with Difficult People,	All Staff, All Staff,	All Staff	Woodstock, IL		
8/1/2016	610090-4006-30	CE Solutions	Bloodborn Pathogens and Exposure control,	All Staff, All Staff,	All Staff	Woodstock, IL		
10/1/2016	610090-4006-30	CE Solutions	Preventing Pressure Sores,	Nursing Only, Nursing Only,	All Staff	Woodstock, IL		
11/1/2016	610090-4006-30	CE Solutions	Influenza and Health Care,	All Staff, All Staff,	Facility	Woodstock, IL		
							18066.49	

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA -$8448**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,666** 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. **N/A**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **314,542**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **13,342**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln 14**
d. Have vehicle usage logs been maintained? **No**
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees