FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 1/1/1956

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 12/1/2017 to 11/30/2018 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, Healthcare
(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: 12/1/2017 Ending: 11/30/2018

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	46,720	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	46,720	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	20,196	14,374	7,825	42,395	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,196	14,374	7,825	42,395	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.74%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 3,838

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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: 12/1/2017 Ending: 11/30/2018

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	507,566	38,016	11,311	556,893		556,893		556,893			1
2	Food Purchase		478,725		478,725		478,725	(11,403)	467,322			2
3	Housekeeping	283,163	59,625	745	343,533		343,533		343,533			3
4	Laundry	144,105	47,303		191,408		191,408		191,408			4
5	Heat and Other Utilities			146,918	146,918		146,918		146,918			5
6	Maintenance	101,543	939	196,853	299,335		299,335	(44)	299,291			6
7	Other (specify):*											7
8	TOTAL General Services	1,036,377	624,608	355,827	2,016,812		2,016,812	(11,447)	2,005,365			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,631,073	240,154	95,823	3,967,050		3,967,050	(9,120)	3,957,930			10
10a	Therapy	95,067	2,542		97,609		97,609		97,609			10a
11	Activities	172,207	15,036	3,542	190,785		190,785		190,785			11
12	Social Services	229,706		3,745	233,451		233,451		233,451			12
13	CNA Training											13
14	Program Transportation			966	966		966		966			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,128,053	257,732	140,076	4,525,861		4,525,861	(9,120)	4,516,741			16
	C. General Administration											
17	Administrative	194,965			194,965		194,965		194,965			17
18	Directors Fees											18
19	Professional Services			47,594	47,594		47,594		47,594			19
20	Dues, Fees, Subscriptions & Promotions			16,167	16,167		16,167	(7,325)	8,842			20
21	Clerical & General Office Expenses	280,370	12,025	632,691	925,086		925,086	(509,915)	415,171			21
22	Employee Benefits & Payroll Taxes			2,906,797	2,906,797		2,906,797		2,906,797			22
23	Inservice Training & Education			182	182		182		182			23
24	Travel and Seminar			25,151	25,151		25,151	(2,060)	23,091			24
25	Other Admin. Staff Transportation			7,364	7,364		7,364	(2,994)	4,370			25
26	Insurance-Prop.Liab.Malpractice			350,495	350,495		350,495		350,495			26
27	Other (specify):*											27
28	TOTAL General Administration	475,335	12,025	3,986,441	4,473,801		4,473,801	(522,294)	3,951,507			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,639,765	894,365	4,482,344	11,016,474		11,016,474	(542,861)	10,473,613			29

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

Facility Name & ID Number Valley HI Nursing Home #0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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			560,658	560,658		560,658		560,658			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			36,306	36,306		36,306		36,306			35
36	Other (specify):*											36
37	**TOTAL Ownership**			596,964	596,964		596,964		596,964			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,221	746,173	896,394		896,394		896,394			39
40	Barber and Beauty Shops		1,065		1,065		1,065		1,065			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			304,121	304,121		304,121		304,121			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		151,286	1,050,294	1,201,580		1,201,580		1,201,580			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,639,765	1,045,651	6,129,602	12,815,018		12,815,018	(542,861)	12,272,157			45

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

Valley Hi Nursing Home
0046821
SUPPLEMENTAL SCHEDULE
12/01/17 - 11/30/18

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILEAGE	FOOD	Events Reimbursement	Train/Cab/Tolls/Par	HOTEL	TOTAL	
FY2018	Thomas Annarella	Administrator	**Springfield, IL**	**IHCA Board of Directors Meeting**	914.92			7.00		921.92	
1/29/18	Thomas Annarella	Administrator	Springfield, IL	IHCA Board of Directors Meeting					126.56	126.56	
6/11/18	Thomas Annarella	Administrator	San Diego, CA	AHCA NCAL 67th Annual Convention Expo				378.96		378.96	ADJ
9/14/18	Thomas Annarella	Administrator	Peoria, IL	IHCA Annual Convention	192.93	2.19			680.80	875.92	
10/11/18	Thomas Annarella	Administrator	San Diego, CA	AHCA NCAL 67th Annual Convention Expo				78.45	1,239.92	1,318.37	ADJ
2/28/18	Thomas Annarella	Administrator	Springfield, IL	IHCA Committee Chair Meeting	227.47					227.47	
	Thomas Annarella	Administrator	Springfield, IL	IHCA Leaders Meeting	454.94					454.94	
6/15/18	Thomas Annarella	Administrator	Oakbrook, IL	Speaking at Forum Post Acuteand Long Term Care	30.08					30.08	
										0.00	
										0.00	
				TOTAL FOR ADMIN ACCT #'s	1,820.34	2.19	0.00	464.41	2,047.28	4,334.22	
					610010-5040-10	**610010-5050-10**	**610010-5050-30**	**610010-5050-40**	**610010-5050-20**	**2,636.89**	
										0.00	
										0.00	
										0.00	
				TOTAL FOR DIETARY ACCT #'s	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	
					610040-5040-10	**610040-5050-10**	**610040-5050-30**	**610040-5050-40**	**610040-5050-20**		
9/13/18	Dawn Redner	Nursing	Peoria, IL	IHCA Annual Convention		44.44			510.60	555.04	
9/13/18	Heather Harmon	Nursing	Peoria, IL	IHCA Annual Convention	176.59	54.95				231.54	
9/13/18	Meghan Judson	Nursing	Peoria, IL	IHCA Annual Convention		57.35				57.35	
9/14/18	First National Bank of Omaha	Nursing	Peoria, IL	IHCA Annual Convention					510.60	510.60	
6/16/18	Meghan Judson	Nursing	Minneapolis, MN	APIC Conference	42.84	90.85				133.69	ADJ
6/15/18	Dawn Redner	Nursing	Minneapolis, MN	APIC Conference	349.58	79.27			734.81	1,163.66	ADJ
	Dawn Redner	Nursing	Naperville, IL	Long Term Care Survey Process						0.00	
	Meghan Judson	Nursing	Peoria, IL	IHCA Annual Convention						0.00	
				TOTAL FOR NURSING ACCT #'s	569.01	326.86	0.00	0.00	1,756.01	2,651.88	
					610050-5040-10	**610050-5050-10**	**610050-5050-30**	**610050-5050-40**	**610050-5050-20**	**1,354.53**	
9/13/18	Linda Barrett	Activities	Peoria, IL	IHCA Annual Convention		61.89		31.82		93.71	
1/12/18	Linda Barrett	Activities	Mundelein, IL	Pick up Emergency Supplies for Isolation Purposes	48.61					48.61	
	Linda Barrett	Activities	Crystal Lake, IL	Fed Ex to pick up Activities Monthly Calendars	71.79					71.79	
8/21/18	Linda Barrett	Activities	Woodstock, IL	Green Garden to pick up dinner for residents	8.28					8.28	
7/20/18	Linda Barrett	Activities	Woodstock, IL	Walmart to pick up supplies	9.16					9.16	
5/23/18	Linda Barrett	Activities	Hebron, Il	Crandalls to pick up dinner for residents	14.22					14.22	
6/22/18	Marla Burkart	Activities	DeKalb, IL	Northern IL Activity Professionals Conference	45.02					45.02	
9/18/18	Linda Barrett	Activities	McHenry, IL	Driving School (for facility bus) - Shah Center	13.79					13.79	
9/18/18	Erin Eiserman	Activities	McHenry, IL	Driving School (for facility bus) - Shah Center	18.97					18.97	
9/18/18	Gwen Lagerhausen	Activities	McHenry, IL	Driving School (for facility bus) - Shah Center	14.17					14.17	
7/26/18	Marla Burkart	Activities	McHenry, IL	Driving School (for facility bus) - Shah Center	16.30					16.30	
1/11/18	Sue Bowe	Activities	McHenry, IL	Driving School (for facility bus) - Shah Center	24.42					24.42	
				TOTAL FOR ACTIVITY ACCT #'s	**284.73**	**61.89**	**0.00**	**31.82**	**0.00**	**378.44**	
					610070-5040-10	**610070-5050-10**	**610070-5050-30**	**610070-5050-40**	**610070-5050-20**	**7,364.54**	
										Adjustment	-2,995.00
										Adjusted Total	**4,369.54**

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,403)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,344)	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	(3,170)	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	(518,176)	21		24
25	Fund Raising, Advertising and Promotional	(4,155)	20		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	(14,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (564,466)		$	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))**	$ (564,466)		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: 12/1/2017

Ending: 11/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Rebate Medical	$ (9,066)	10	1
2	Offset Scrap Revenue	(44)	6	2
3	Offset Medical Records Revenue	(54)	10	3
4	Non-Allowable - Seminar Expense	(2,060)	24	4
5	Non-Allowable Travel	(2,994)	25	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
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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**	(14,218)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,403)	0	0	0	0	0	0	0	0	0	0	(11,403)	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	(44)	0	0	0	0	0	0	0	0	0	0	(44)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,447)	0	0	0	0	0	0	0	0	0	0	(11,447)	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	(9,120)	0	0	0	0	0	0	0	0	0	0	(9,120)	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**	(9,120)	0	0	0	0	0	0	0	0	0	0	(9,120)	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	(7,325)	0	0	0	0	0	0	0	0	0	0	(7,325)	20
21	Clerical & General Office Expenses	(531,520)	21,605	0	0	0	0	0	0	0	0	0	(509,915)	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	(2,060)	0	0	0	0	0	0	0	0	0	0	(2,060)	24
25	Other Admin. Staff Transportation	(2,994)	0	0	0	0	0	0	0	0	0	0	(2,994)	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**	(543,899)	21,605	0	0	0	0	0	0	0	0	0	(522,294)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(564,466)	21,605	0	0	0	0	0	0	0	0	0	(542,861)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Valley HI Nursing Home # 0046821 **Report Period Beginning:** 12/1/2017 **Ending:** 11/30/2018

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	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(564,466)	21,605	0	0	0	0	0	0	0	0	0	(542,861)	45

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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		$	$	1
2	V	21	Office		McHenry County		21,605	21,605	2
3	V						8,542	8,542	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			$			$ 30,147	$ * 30,147	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: 12/1/2017 Ending: 11/30/2018

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 Gov't.	1
2	Christopher Spoerl	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 Aavang	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: 12/1/2017 Ending: 11/30/2018

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: 12/1/2017 Ending: 1/30/2018

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: 12/1/2017 Ending: 11/30/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	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: 12/1/2017 Ending: 11/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

County operated facility does not pay real estate tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 12/1/2017 Ending: 11/30/2018

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: 12/1/2017 Ending: 11/30/2018

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	128		2006	2006	$ 13,881,312	$	40	$ 347,033	$ 347,033	$ 4,212,730	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	15,629		20			15,629	9
10	Various			1989	400,744		20			400,744	10
11	Various			1994	21,235		20			21,235	11
12	Various			1996	695,585		20			695,585	12
13	Various			2006	25,425		20			25,425	13
14	Various			2007	19,483		20	974	974	10,714	14
15	Various			2008	80,862		20	4,043	4,043	12,121	15
16	Various			2009	3,751		20	188	188	1,692	16
17	Various			2010	120,395		20	6,020	6,020	48,160	17
18	Various			2011	92,299		20	4,615	4,615	32,305	18
19	Various			2012	28,004		20	1,400	1,400	8,400	19
20	Various			2013	28,347		14	2,792	2,792	14,682	20
21	Various			2014	63,329		12	4,733	4,733	20,436	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	Current Book Depreciation					560,658			(560,658)		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: 12/1/2017 Ending: 11/30/2018

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	Dock Door Frame	2015	$ 2,530	$	10	$ 253	$ 253	$ 801	37
38	DCEO Energy Efficiency Program	2015	210,063		20	10,503	10,503	39,836	38
39	Architect: Flooring Nurses Stations/ Halls	2016	13,600		10	1,360	1,360	3,173	39
40	Flooring Laminate: Nurses Stations/ Halls	2016	168,599		10	16,860	16,860	39,340	40
41	Sealcoat, Repair and re-stripe parking lot	2016	37,061		10	3,706	3,706	7,721	41
42	Irrigation repairs	2017	3,612		7	516	516	731	42
43	Pond liner repairs	2017	5,913		15	394	394	427	43
44	West Courtyard Drainage Project	2018	7,853		10	327	327	327	44
45	West Courtyard Island Planting	2018	4,640		5	387	387	387	45
46	Pond Bubbler Wiring	2018	2,764		7	33	33	33	46
47									47
48									48
49									49
50									50
51									51
52									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									69
70	TOTAL (lines 4 thru 69)		$ 15,933,035	$ 560,658		$ 406,137	$ (154,521)	$ 5,612,634	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: 12/1/2017 Ending: 11/30/2018

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	$ 1,480,022	$	$ 154,521	$ 154,521		$ 1,421,153	71
72	Current Year Purchases	135,523						72
73	Fully Depreciated Assets							73
74	Disposals	(41,349)						74
75	TOTALS	$ 1,574,196	$	$ 154,521	$ 154,521		$ 1,421,153	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	$ 40,035	76
77		2011 Chevy Equinox Car	2011	20,445				5	20,445	77
78		Tractor	1985	10,684				5	10,684	78
79										79
80	TOTALS			$ 71,164	$	$	$		$ 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)	$ 17,584,395	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 560,658	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 560,658	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,104,951	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: 12/1/2017 Ending: 11/30/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 36,306 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
12/1/2017- 11/30/2018

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Description	Amount
Photo Copier	11,792
Dish Machine	2,400
Water Coolers	190
Tents for Resident Picnic	4,602
Tables for Resident Picnic	812
Chairs for Resident Picnic	409
Cotton Candy Machine	180
Hand Washing stations for Resident Picnic	100
Consonus rehab ACPL Equipment	3,799
Cutter	22
Avaya Telephone Equipment	12,000
	36,306

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 267,756	$		$ 267,756	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			123,298			123,298	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			355,119			355,119	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				95,692		95,692	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					54,529		54,529	13
14	TOTAL			$		$ 746,173	$ 150,221		$ 896,394	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/Insurance	12,388
X-Rays Medicare Part A	5,304
Rental of Medical Equipment	24,070
Medical Services - Outpatient Pt. A	12,767
Medical Transport	0
Total	54,529

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2018 (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	$ 20,115,379	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (425,000))	3,633,716		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	28,161		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	20,782,326		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 44,559,582	$	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	1,285,512		15
16	Equipment, at Historical Cost	2,187,077		16
17	Accumulated Depreciation (book methods)	(7,004,035)		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)**	$ 11,035,994	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 55,595,576	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 176,153	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	242,573		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	371,466		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 790,192	$	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	See Attached	3,702,471		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,702,471	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,492,663	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 51,102,913	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 55,595,576	$	48

*(See instructions.)

Line #	Other Current Assets:	Amount	Amount
9	Interest Receivable	111,777	
9	DOR- Pensions(GASB 68)	779,596	
9	Property Tax Receivable	10,000	
9	DIR-Pensions (GASB68	(346,697)	
9	DOR-Contr.Sub to Ms Date (GASB68)	1,097,853	
9	Investments	19,129,797	
	Total Line 9	20,782,326	

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

Line #	Other Non-Current Liabilities:	Amount	Amount
36	Bed Tax Liability	50,866	
36	Due to HFS	47,346	
36	Due to General Fund	281	
36	Due to Employee Benefit Fund	-	
36	Due to Other Cnty. Depts.	247,995	
36	Deferred Interest Revenue	14,978	
36	Deferred Property Tax Revenue	10,000	
	Total Line 36	371,466	

Line #	Other Non-Current Liabilities:	Amount	Amount
43	OPEB Liability	641,305	
43	Net Pension Liability (GASB 68)	2,928,475	
43	Compensated Absecenses Payable	132,691	
	Total Line 43	3,702,471	

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 52,639,552	1
2	Restatements (describe):		2
3	**Restatement of Beginning FB-Chg. In Accounting Principal**	203,441	3
4	**Audit Adjustment Equity Difference**	(433,123)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 52,409,870	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,306,957)	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)**	$ (1,306,957)	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)**	$ 51,102,913	24 *

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

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	$ 11,549,325	1
2	Discounts and Allowances for all Levels	(2,363,818)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,185,507	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,315,290	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,315,290	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	11,403	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	78,112	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,195	19
20	Radiology and X-Ray	1,974	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 102,684	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	895,416	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 895,416	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other Misc. Income (Adj P.5)**	9,164	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,164	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,508,061	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,016,812	31
32	Health Care	4,525,861	32
33	General Administration	4,473,801	33
	B. Capital Expense		
34	Ownership	596,964	34
	C. Ancillary Expense		
35	Special Cost Centers	897,459	35
36	Provider Participation Fee	304,121	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,815,018	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,306,957)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,306,957)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,031,492	44
45	Private Pay - Net Inpatient Revenue	3,298,741	45
46	Medicare - Net Inpatient Revenue	1,101,550	46
47	Other-(specify) **Insurance**	138,098	47
48	Other-(specify) **Hospice**	615,626	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,185,507	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.**

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	1,704	2,080	$ 86,211	$ 41.45	1
2	Assistant Director of Nursing	1,687	2,080	67,457	32.43	2
3	Registered Nurses	38,455	43,752	1,338,364	30.59	3
4	Licensed Practical Nurses	16,037	18,717	522,766	27.93	4
5	CNAs & Orderlies	96,268	106,803	1,405,504	13.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,857	4,870	95,067	19.52	8
9	Activity Director	1,751	2,177	47,563	21.85	9
10	Activity Assistants	10,179	11,369	124,644	10.96	10
11	Social Service Workers	7,587	8,796	229,706	26.11	11
12	Dietician					12
13	Food Service Supervisor	4,024	4,523	86,969	19.23	13
14	Head Cook	3,806	4,646	61,771	13.30	14
15	Cook Helpers/Assistants	5,765	6,743	88,276	13.09	15
16	Dishwashers	21,251	24,535	270,550	11.03	16
17	Maintenance Workers	3,326	3,964	101,543	25.62	17
18	Housekeepers	21,695	25,939	283,163	10.92	18
19	Laundry	9,461	10,516	144,105	13.70	19
20	Administrator	1,932	2,080	120,573	57.97	20
21	Assistant Administrator	1,820	2,080	74,392	35.77	21
22	Other Administrative	6,247	7,363	179,080	24.32	22
23	Office Manager					23
24	Clerical	6,578	7,432	101,290	13.63	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	1,716	2,051	47,168	23.00	31
32	Other Health Care(specify)					32
33	Other(specify) Supply/Unit Clerk	11,125	12,749	163,603	12.83	33
34	TOTAL (lines 1 - 33)	276,271	315,265	$ 5,639,765 *	$ 17.89	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	223	$ 11,311	1-3	35
36	Medical Director	Monthly	36,000	9-3	36
37	Medical Records Consultant	15	1,119	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	48	3,542	11-3	44
45	Social Service Consultant	49	3,745	12-3	45
46	Other(specify)				46
47	Dental Services	Monthly	19,905	10-3	47
48					48
49	TOTAL (lines 35 - 48)	335	$ 77,158		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	45	$ 2,925	10-3	50
51	Licensed Practical Nurses	42	1,778	10-3	51
52	Certified Nurse Assistants/Aides	868	29,111	10-3	52
53	TOTAL (lines 50 - 52)	955	$ 33,814		53

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Annarella	Administrator	0%	$ 120,573
Tara Goosens	Asst. Admin.	0%	74,392
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 194,965

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	7,000
FGMK, LLC	Cost Report/Consulting	8,260
Management Performance Assoc.	Management Audit	34,695
Episode Alert	Medicare Software	130
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 50,085

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	446,688
Employee Health Insurance	1,439,523
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	513,751
Employee Physicals	7,195
Pension Expense	498,000
Other Employee Benefits	1,640
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,906,797

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	$ 1,990
Advertising: Employee Recruitment	960
Health Care Worker Background Check	
(Indicate # of checks performed 36)	1,267
Patient Background Checks 100	1,000
Subscriptions/Licenses/Permits	2,193
Dues	4,986
Publications/Classified Ads	601
Advertising & Promotions	4,155
Less: Public Relations Expense	( )
Non-allowable advertising	(4,155)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,997

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	23,091
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,091

* Attach copy of IMRF notifications

**See instructions.

DATE	G/L ACCT#	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
01/11/18	**610010-4006-10**	First National Bank of Omaha	IHCA Public Policy Forum	Thomas Annarella	Administrator	Arlington Heights, IL	30.00	
02/12/18	610010-4006-10	First National Bank of Omaha	PESI Innovation Intervention for the Aging Brain	Debprah Huml	Social Services	Palatine, IL	199.99	
04/18/18	610010-4006-10	First National Bank of Omaha	AHCA NCAL Convention	Thomas Annarella	Administrator	San Diego, CA	750.00	ADJ
08/15/18	610010-4006-10	First National Bank of Omaha	IHCA Annual Convention	Admin Staff	Administration	Peoria, IL	189.00	
12/31/17	**610010-4006-30**	First National Bank of Omaha	ROP Facility Assessment Requirements	Tom & Tara	Administrator	Woodstock, IL	129.00	
12/20/17	610010-4006-30	Murray, Cristina	Basic Life Support CPR	Tara Goossens	Asst Administrator	Woodstock, IL	20.00	
01/18/18	610010-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Tara Goossens	Asst Administrator	Woodstock, IL	28.34	
02/16/18	610010-4006-30	First National Bank of Omaha	The New Survey Process for Social Workers	Deborah & Deb	Social Services	Woodstock, IL	129.00	
02/17/18	610010-4006-30	First National Bank of Omaha	F-Tag Review of Regulations - Food Safety	Tara Goossens	Asst Administrator	Woodstock, IL	55.00	
03/14/18	610010-4006-30	First National Bank of Omaha	Survery Prep-Anfection Control Antibiotic Stewardship	Tara Goossens	Asst Administrator	Woodstock, IL	43.00	
03/14/18	610010-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Tom & Tara	Administrator	Woodstock, IL	33.33	
04/06/18	610010-4006-30	First National Bank of Omaha	ICD-10 Training	Tom & Tara	Administrator	Woodstock, IL	199.60	
05/24/18	610010-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Tara Goossens	Asst Administrator	Woodstock, IL	28.33	
08/10/18	610010-4006-30	First National Bank of Omaha	Alarms - The New Deficient Practice	Thomas Annarella	Administrator	Woodstock, IL	43.00	
08/10/18	610010-4006-30	First National Bank of Omaha	Alarms - The New Deficient Practice Part 2	Thomas Annarella	Administrator	Woodstock, IL	43.00	
10/15/18	610010-4006-30	First National Bank of Omaha	MDS Coding for Social Workers & Activities	Deborah & Deb	Social Services	Woodstock, IL	64.50	
10/31/18	610010-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Tara Goossens	Asst Administrator	Woodstock, IL	27.50	
11/18/18	610010-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Tara Goossens	Asst Administrator	Woodstock, IL	28.34	
07/09/18	610010-4006-30	Durham Group	Executive Coaching and Team Development	Admin Staff	Administration	Woodstock, IL	2,291.69	
07/09/18	**610020-4006-30**	Durham Group	Executive Coaching and Team Development	Chuck Martens	Laundry	Woodstock, IL	104.17	
07/09/18	**610030-4006-30**	Durham Group	Executive Coaching and Team Development	Chuck Martens	Laundry	Woodstock, IL	104.16	
03/27/18	**610040-4006-10**	Romero, Haley	Manager/Supervisor Seminar	Haley Romero	Dietary	Woodstock, IL	99.00	
12/01/17	**610040-4006-30**	Murray, Cristina	Basic Life Support CPR	Dietary Staff	Dietary	Woodstock, IL	20.00	
07/09/18	610040-4006-30	Durham Group	Executive Coaching and Team Development	Dietary Staff	Dietary	Woodstock, IL	416.66	
04/12/18	**610050-4006-10**	First National Bank of Omaha	APIC Convention in MN	Dawn & Meghan	Nursing	Minneapolis, MN	1,310.00	ADJ
08/15/18	610050-4006-10	First National Bank of Omaha	IHCA Annual Convention	Nursing Staff	Nursing	Peoria, IL	657.00	
10/30/18	610050-4006-10	First National Bank of Omaha	SNF PPS FY 2019 Final Rule	Beth Partridge	MDS Coordinator	Woodstock, IL	209.00	
12/01/17	**610050-4006-30**	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	160.00	
12/20/17	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	120.00	
12/29/17	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	100.00	
05/04/18	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	200.00	
07/27/18	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	200.00	
01/18/18	610050-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Dawn & Meghan	Nursing	Woodstock, IL	56.66	
03/14/18	610050-4006-30	First National Bank of Omaha	Survery Prep-Anfection Control Antibiotic Stewardship	Dawn & Meghan	Nursing	Woodstock, IL	86.00	
03/14/18	610050-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Dawn & Meghan	Nursing	Woodstock, IL	66.67	
04/06/18	610050-4006-30	First National Bank of Omaha	ICD-10 Training	Dawn & Meghan	Nursing	Woodstock, IL	299.40	
04/25/18	610050-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Dawn & Meghan	Nursing	Woodstock, IL	70.00	
05/24/18	610050-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Dawn & Meghan	Nursing	Woodstock, IL	56.67	
07/18/18	610050-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Dawn Redner	DON	Woodstock, IL	55.00	
07/18/18	610050-4006-30	First National Bank of Omaha	MDS 3.0 What's Coming in October	Dawn Redner	DON	Woodstock, IL	60.00	
08/10/18	610050-4006-30	First National Bank of Omaha	Alarms - The New Deficient Practice	Dawn & Meghan	Nursing	Woodstock, IL	86.00	
08/10/18	610050-4006-30	First National Bank of Omaha	Alarms - The New Deficient Practice Part 2	Dawn & Meghan	Nursing	Woodstock, IL	86.00	
10/01/18	610050-4006-30	First National Bank of Omaha	MDS 3.0 RAI User's Manual	Beth Partridge	MDS Coordinator	Woodstock, IL	229.00	
10/15/18	610050-4006-30	First National Bank of Omaha	MDS Coding for Social Workers & Activities	Beth Partridge	MDS Coordinator	Woodstock, IL	32.25	
10/31/18	610050-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Beth Partridge	MDS Coordinator	Woodstock, IL	27.50	
11/18/18	610050-4006-30	First National Bank of Omaha	F-Tag Review of Regulations	Beth Partridge	MDS Coordinator	Woodstock, IL	56.66	
07/09/18	610050-4006-30	Durham Group	Executive Coaching and Team Development	Nursing Staff	Nursing	Woodstock, IL	1,874.99	
08/15/18	**610070-4006-10**	First National Bank of Omaha	IHCA Annual Convention	Linda Barrett	Activities	Peoria, IL	189.00	
06/15/18	610070-4006-10	Northern IL Activity Professionals	Education Equals Quality Care	Activties Staff	Activities	Peoria, IL	120.00	
05/04/18	**610070-4006-30**	Murray, Cristina	Basic Life Support CPR	Activties Staff	Activities	Woodstock, IL	25.00	
10/15/18	610070-4006-30	First National Bank of Omaha	MDS Coding for Social Workers & Activities	Linda Barrett	Activities	Woodstock, IL	32.25	
07/09/18	610070-4006-30	Durham Group	Executive Coaching and Team Development	Linda Barrett	Activities	Woodstock, IL	208.33	
FY2018	**610090-4006-30**	Relias Learning	In-house Webinar Courses (deposit)	Staff	Staff	Woodstock, IL	8,200.00	
FY2018	610090-4006-30	Relias Learning	In-house Webinar Courses (balance)	Staff	Staff	Woodstock, IL	5,200.00	
							25149.99	
						Adjusted Total	23090	

Facility Name & ID Number Valley HI Nursing Home # 0046821 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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 - $4986**

(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? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **60,367** 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. $ **304,121**
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. $ **11,403**

(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: **Beker Tilly/Virchaw Kraus (Scheduled Not competed)**

(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