FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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) 940-3269
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 12/1/2019 to 11/30/2020 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) 940-3269 Fax # (847) 964-5469

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: 12/1/2019 Ending: 11/30/2020

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	19,548	9,021	8,592	37,161	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,548	9,021	8,592	37,161	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.32%

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 3,009

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: 12/1/2019 Ending: 11/30/2020

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	607,462	33,772	15,448	656,682		656,682		656,682			1
2	Food Purchase		455,569		455,569		455,569	(5,437)	450,132			2
3	Housekeeping	287,512	45,407	785	333,704		333,704		333,704			3
4	Laundry	139,468	36,253		175,721		175,721		175,721			4
5	Heat and Other Utilities			138,375	138,375		138,375		138,375			5
6	Maintenance	109,671	9,285	173,452	292,408		292,408	(4,259)	288,149			6
7	Other (specify):*											7
8	TOTAL General Services	1,144,113	580,286	328,060	2,052,459		2,052,459	(9,696)	2,042,763			8
	B. Health Care and Programs											
9	Medical Director			41,500	41,500		41,500		41,500			9
10	Nursing and Medical Records	3,747,573	415,324	381,631	4,544,528		4,544,528	(7,355)	4,537,173			10
10a	Therapy	118,855	1,502		120,357		120,357		120,357			10a
11	Activities	187,005	10,895	445	198,345		198,345		198,345			11
12	Social Services	198,610		1,122	199,732		199,732		199,732			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,252,043	427,721	424,698	5,104,462		5,104,462	(7,355)	5,097,107			16
	C. General Administration											
17	Administrative	193,755			193,755		193,755		193,755			17
18	Directors Fees											18
19	Professional Services			22,225	22,225		22,225		22,225			19
20	Dues, Fees, Subscriptions & Promotions			24,858	24,858		24,858	(2,683)	22,175			20
21	Clerical & General Office Expenses	353,354	10,339	592,273	955,966		955,966	(511,334)	444,632			21
22	Employee Benefits & Payroll Taxes			2,611,708	2,611,708		2,611,708		2,611,708			22
23	Inservice Training & Education			2,612	2,612		2,612		2,612			23
24	Travel and Seminar			19,937	19,937		19,937		19,937			24
25	Other Admin. Staff Transportation			723	723		723		723			25
26	Insurance-Prop.Liab.Malpractice			346,068	346,068		346,068		346,068			26
27	Other (specify):*											27
28	TOTAL General Administration	547,109	10,339	3,620,404	4,177,852		4,177,852	(514,017)	3,663,835			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,943,265	1,018,346	4,373,162	11,334,773		11,334,773	(531,068)	10,803,705			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 SCHEDULE
12/01/19 - 11/30/20

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILEAGE	MEALS	Train/Cab/Tolls/Park	HOTEL	TOTAL
	Thomas Annarella	Administrator	**Springfield, IL**	**IHCA Board of Directors Meeting**	722.78				722.78
				TOTAL FOR ADMIN ACCT #'s	**722.78**	**0.00**	**0.00**	**0.00**	**722.78**
					6100-504000	**6100-505010**	**6100-505040**	**6100-505020**	

Facility Name & ID Number Valley Hi Nursing Home #0046821 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			605,595	605,595		605,595		605,595			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			25,678	25,678		25,678		25,678			35
36	Other (specify):*											36
37	**TOTAL Ownership**			631,273	631,273		631,273		631,273			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,906	586,868	748,774		748,774		748,774			39
40	Barber and Beauty Shops		365		365		365		365			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			277,478	277,478		277,478		277,478			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		162,271	864,346	1,026,617		1,026,617		1,026,617			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,943,265	1,180,617	5,868,781	12,992,663		12,992,663	(531,068)	12,461,595			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: 12/1/2019 Ending: 11/30/2020

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	(5,437)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,701)	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	(150)	20		18
19	Entertainment				19
20	Contributions	(2,533)	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	(530,255)	21		24
25	Fund Raising, Advertising and Promotional	(3,532)	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	(11,614)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (566,222)		$	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))**	$ (566,222)		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: 12/1/2019

Ending: 11/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Maintenance Revenue	$ (4,259)	6	1
2	Offset Medical Revenue/Rebates	(7,355)	10	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,614)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	(5,437)	0	0	0	0	0	0	0	0	0	0	(5,437)	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	(4,259)	0	0	0	0	0	0	0	0	0	0	(4,259)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,696)	0	0	0	0	0	0	0	0	0	0	(9,696)	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	(7,355)	0	0	0	0	0	0	0	0	0	0	(7,355)	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**	(7,355)	0	0	0	0	0	0	0	0	0	0	(7,355)	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	(2,683)	0	0	0	0	0	0	0	0	0	0	(2,683)	20
21	Clerical & General Office Expenses	(546,488)	35,154	0	0	0	0	0	0	0	0	0	(511,334)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(549,171)	35,154	0	0	0	0	0	0	0	0	0	(514,017)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(566,222)	35,154	0	0	0	0	0	0	0	0	0	(531,068)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Valley Hi Nursing Home # 0046821 **Report Period Beginning:** 12/1/2019 **Ending:** 11/30/2020

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)**	(566,222)	35,154	0	0	0	0	0	0	0	0	0	(531,068)	45

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	Computer/IT Support	$	McHenry County		$ 26,612	$ 26,612	1
2	V	21	Office (Payroll/Checks, etc.)		McHenry County		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			$			$ 35,154	$ * 35,154	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: 12/1/2019 Ending: 11/30/2020

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	Michael Vijuk	BOD						2
3	Thomas Wilbeck	BOD						3
4	Robert "Bob" Nowak	BOD						4
5	Carolyn Schofield	BOD						5
6	Jeffrey Thorsen	BOD						6
7	Suzanne Ness	BOD						7
8	John Reinert	BOD						8
9	Joseph Gottemoller	BOD						9
10	Kelli Wegener	BOD						10
11	Chris Christensen	BOD						11
12	Lori Parrish	BOD						12
13	Kay R. Bates	BOD						13
14	Steve Doherty	BOD						14
15	Pamela Althoff	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	Carlos Acosta	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: 12/1/2019 Ending: 11/30/2020

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: 12/1/2019 Ending: 1/30/2020

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	21	Computer/IT Support	Direct Cost	1	1	$ 26,612	$	1	$ 26,612	1
2	21	Office (Payroll, Checks, Etc.)	Direct Cost	1	1	8,542		1	8,542	2
3										3
4										4
5										5
6		Data available from McHenry County upon request.								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					$ 35,154	$		$ 35,154	25

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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							$	$			$	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: 12/1/2019 Ending: 11/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

County operated facility does not pay real estate tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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) 940-3269 FAX #: (847) 964-5469

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 12/1/2019 Ending: 11/30/2020

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: 12/1/2019 Ending: 11/30/2020

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	$ 4,906,796	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	974	974	12,662	14
15	Various			2008	80,862		20	4,043	4,043	20,207	15
16	Various			2009	3,751		20	188	188	2,068	16
17	Various			2010	120,395		20	6,020	6,020	60,200	17
18	Various			2011	92,299		20	4,615	4,615	41,535	18
19	Various			2012	28,004		20	1,400	1,400	11,200	19
20	Various			2013	28,347		14	2,792	2,792	20,266	20
21	Various			2014	63,329		12	4,733	4,733	29,902	21
22	Various			2015	212,593		20	10,756	10,756	62,149	22
23	Various			2016	219,260		10	21,926	21,926	94,086	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	Current Book Depreciation					605,595					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: 12/1/2019 Ending: 11/30/2020

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	Irrigation repairs	2017	$ 3,612	$	7	$ 516	$ 516	$ 1,763	37
38	Pond liner repairs	2017	5,913		15	394	394	1,215	38
39	West Courtyard Drainage Project	2018	7,853		10	786	786	1,899	39
40	West Courtyard Island Planting	2018	4,640		5	928	928	2,243	40
41	Pond Bubbler Wiring	2018	2,764		7	690	690	1,413	41
42	Outside Wall Hydrant Valve replacement	2018	3,772		10	377	377	754	42
43	Elevator Replace Packing Around Cylinder	2019	10,560		10	1,056	1,056	1,232	43
44	West Courtyard Planting & Remove Existing Irrgtn. Syst..	2019	15,323		5	3,065	3,065	4,853	44
45	East Courtyard Beautification - Drainage	2019	11,571		10	1,157	1,157	1,639	45
46	East Courtyard Planting	2019	9,638		5	1,928	1,928	2,731	46
47	Sealcoat, Repair and re-stripe parking lot	2019	2,342		5	468	468	936	47
48	Sidewalks Concrete Leveling	2019	6,215		5	1,243	1,243	1,761	48
49	27 Axis Outdoor/Indoor Security Cameras	2019	23,533		5	4,707	4,707	5,099	49
50	27 Genetech Security Camera Licenses	2019	7,831		5	1,566	1,566	1,697	50
51	Security Camera Installation, Labor and Materials	2019	38,512		5	7,702	7,702	8,344	51
52	Security Camera add'l labor to remove and recycle cameras and c	2020	3,990		5	785	785	785	52
53	Well Pump Package and Electrical upgrades	2020	33,944		15	2,128	2,128	2,128	53
54	Gravel Storage Room improvements (concrete, piping, electrical)	2020	29,886		15	1,760	1,760	1,760	54
55	Airflow Project - HVAC System	2020	3,900		15	22	22	22	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)		$ 16,134,052	$ 605,595		$ 435,758	$ 435,758	$ 5,303,345	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: 12/1/2019 Ending: 11/30/2020

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	$ 1,591,994	$	$ 155,073	$ 155,073		$ 1,655,925	71
72	Current Year Purchases	42,806		3,180	3,180		460,616	72
73	Fully Depreciated Assets	460,616					371,347	73
74	Disposals	(6,498)						74
75	TOTALS	$ 2,088,918	$	$ 158,253	$ 158,253		$ 2,487,888	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		Ford E350 Diamond Coach	2019	$ 57,919	$	$ 11,584	$ 11,584	5	$ 17,376	76
77		2011 Chevy Equinox	2011	20,445					20,445	77
78		Tractor	1985	10,684					10,684	78
79										79
80	TOTALS			$ 89,048	$	$ 11,584	$ 11,584		$ 48,505	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)	$ 18,318,018	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 605,595	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 605,595	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)	$ 7,839,738	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	Therapy Room/Shower Reno	$ 52,259	92
93	Facilities Mgmt Software	10,558	93
94			94
95		$ 62,817	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: 12/1/2019 Ending: 11/30/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 25,678 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.

Page 14 Supplemental

Description	Amount
Photo Copier	3,618
Dish Machine	2,400
Water Coolers	167
Consonus Rehab ACPL Equipment	7,304
Cotton Candy Machine	85
Avaya Telephone Equipment	12,000
Pump Rental	104
	25,678

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 249,640	$		$ 249,640	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			76,393			76,393	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			212,955			212,955	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				120,266		120,266	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapist	39-3				47,880			47,880	12
13	Other (specify): See Attached	39-2					41,640		41,640	13
14	TOTAL			$		$ 586,868	$ 161,906		$ 748,774	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	11,548
X-Rays Medicare Part A	2,485
Rental of Medical Equipment	26,822
Medical Services Outpatient Pt. A	785
Total	41,640

STATE OF ILLINOIS

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2020 (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	$ 12,733,539	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (625,000))	2,378,454		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	30,282		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	15,508,566		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 30,650,841	$	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	14,605,658		14
15	Leasehold Improvements, at Historical Cost	1,468,122		15
16	Equipment, at Historical Cost	2,177,966		16
17	Accumulated Depreciation (book methods)	(8,056,591)		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): See Attached	62,817		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,263,972	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 40,914,813	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 259,014	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,828		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	504,015		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,021,857	$	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	5,121,737		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,121,737	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,143,594	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 34,771,219	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 40,914,813	$	48

*(See instructions.)

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Line #	Other Current Assets:	Amount	Amount
9	Interest Receivable	87,929	
9	DOR- Pensions(GASB 68)	713,342	
9	Property Tax Receivable	10,130	
9	DOR-Contra Sub to Ms Date (GASB68)	1,537,084	
9	Deferred Outflows -OPEB (gasb75)	22,669	
9	Investments	13,137,412	
	Total Line 9	15,508,566	

Line #	Other Non-Current Assets:	Amount	Amount
23	Prepayment on Construction Project	62,817	
	Total Line 23	62,817	

Line #	Other Current Liabilities:	Amount	Amount
36	Bed Tax Liability	59,806	
36	Due to HFS	47,006	
36	Due to General Fund	179	
36	Due to Employee Benefit Fund	103,916	
36	Due to Other Cnty. Depts.	282,568	
36	VH Accruals	540	
36	Deferred Property Tax Revenue	10,000	
	Total Line 36	504,015	

Line #	Other Non-Current Liabilities:	Amount	Amount
43	OPEB Liability	763,970	
43	Net Pension Liability (GASB 68)	3,363,894	
43	Compensated Absecenses Payable	160,982	
43	DIR-OPEB (GASB 75)	206,419	
43	DIR - Pensions (GASB68)	626,472	
	Total Line 43	5,121,737	

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 50,182,108	1
2	Restatements (describe):		2
3	Restatement of Beginning FB-Chg, In Accounting Principal	(91,588)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 50,090,520	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,112,029)	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	(14,207,272)	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)**	$ (15,319,301)	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)**	$ 34,771,219	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	$ 11,299,841	1
2	Discounts and Allowances for all Levels	(1,878,356)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,421,485	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	812,362	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 812,362	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	5,437	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	98,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,483	19
20	Radiology and X-Ray	1,532	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 116,423	23
	D. Non-Operating Revenue		
24	Contributions	3,800	24
25	Interest and Other Investment Income***	645,814	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 649,614	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Property Tax/Misc. Income-ADJ, Rebates-ADJ**	18,109	28
28a	**HHS/HFS CARES ACT FUNDING**	862,641	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 880,750	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,880,634	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,052,459	31
32	Health Care	5,104,462	32
33	General Administration	4,177,852	33
	B. Capital Expense		
34	Ownership	631,273	34
	C. Ancillary Expense		
35	Special Cost Centers	749,139	35
36	Provider Participation Fee	277,478	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,992,663	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,112,029)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,112,029)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,223,430	44
45	Private Pay - Net Inpatient Revenue	1,893,637	45
46	Medicare - Net Inpatient Revenue	1,124,630	46
47	Other-(specify) **Insurance**	71,221	47
48	Other-(specify) **Hospice**	1,108,567	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,421,485	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	1,808	2,080	$ 91,428	$ 43.96	1
2	Assistant Director of Nursing	1,757	2,080	71,312	34.28	2
3	Registered Nurses	39,919	45,301	1,465,948	32.36	3
4	Licensed Practical Nurses	14,916	167,770	478,926	2.85	4
5	CNAs & Orderlies	79,268	88,804	1,430,719	16.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,100	4,908	118,855	24.22	8
9	Activity Director	1,755	1,950	39,598	20.31	9
10	Activity Assistants	9,405	11,283	147,407	13.06	10
11	Social Service Workers	5,437	7,590	198,610	26.17	11
12	Dietician					12
13	Food Service Supervisor	3,744	4,160	99,687	23.96	13
14	Head Cook	7,887	8,976	129,018	14.37	14
15	Cook Helpers/Assistants	5,389	6,338	94,821	14.96	15
16	Dishwashers	18,949	21,905	283,936	12.96	16
17	Maintenance Workers	2,993	3,826	109,671	28.66	17
18	Housekeepers	18,159	21,096	287,512	13.63	18
19	Laundry	8,951	10,505	139,468	13.28	19
20	Administrator	1,960	2,080	118,805	57.12	20
21	Assistant Administrator	1,940	2,080	74,950	36.03	21
22	Other Administrative	8,461	9,833	296,136	30.12	22
23	Office Manager					23
24	Clerical	4,322	4,931	57,218	11.60	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	1,529	1,957	48,587	24.83	31
32	Other Health C: Aides	926	1,080	11,292	10.46	32
33	Other(specify) Supply/Unit Clerk	6,980	8,190	149,361	18.24	33
34	TOTAL (lines 1 - 33)	250,555	438,723	$ 5,943,265 *	$ 13.55	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	326	$ 15,448	1-3	35
36	Medical Director	Monthly	41,500	9-3	36
37	Medical Records Consultant	14	1,062	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	6	445	11-3	44
45	Social Service Consultant	16	1,122	12-3	45
46	Other(specify) Dental Services	Monthly	62,650	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	362	$ 123,763		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	243	$ 16,337	10-3	50
51	Licensed Practical Nurses	58	3,318	10-3	51
52	Certified Nurse Assistants/Aides	7,658	296,728	10-3	52
53	TOTAL (lines 50 - 52)	7,959	$ 316,383		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Annarella	Administrator	0%	$ 118,805
Tara Polte	Asst. Admin.	0%	74,950
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 193,755

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
FGMK, LLC	Cost Reporting/Consulting	11,865
Consonus/PCC	Co-Pilot	6,000
NRC Health	Customer/Employee Survey	4,360
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 22,225

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	455,606
Employee Health Insurance	1,316,508
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	515,101
Pensin Expense	315,000
Employee Physicals	8,340
Other Employee Benefits	1,153
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,611,708

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	398
Health Care Worker Background Check	
(Indicate # of checks performed 20)	704
Patient Background Checks 46	460
Subscriptions/Licenses/Permits	8,347
Dues	7,518
Publications	918
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,325

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	19,937
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,937

* Attach copy of IMRF notifications

**See instructions.

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DATE	G/L ACCT#	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
12/02/19	**6100-400600**	RH Sanders	Basic Life Support CPR	Admin Staff	Administration	Woodstock, IL	30.00	
01/05/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	34.35	
01/11/20	6100-400600	First National Bank of Omaha	Pioneering Solutions Workforce Crisis Webinar	Thomas Annarella	Administrator	Woodstock, IL	25.00	
12/06/19	6100-400600	First National Bank of Omaha	Medicare Care Skilling 101 Seminar Part 2	Thomas Annarella	Administration	Woodstock, IL	129.00	
12/13/19	6100-400600	First National Bank of Omaha	Medicare Care Skilling 101 Seminar Part 1	Thomas Annarella	Administration	Woodstock, IL	129.00	
02/04/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	41.25	
02/12/20	6100-400600	Titan CPR Associates	Basic Life Support CPR	Admin Staff	Administration	Woodstock, IL	60.00	
08/01/20	6100-400600	Durham Group	Executive Coaching and Team Development	Admin Staff	Administration	Woodstock, IL	1,925.00	
03/03/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	31.44	
04/07/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	31.44	
05/05/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	36.67	
06/02/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	18.33	
08/04/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	27.50	
09/01/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	27.50	
09/15/20	6100-400600	First National Bank of Omaha	IHCA Annual Convention	Thomas Annarella	Administrator	Woodstock, IL	249.99	
10/06/20	6100-400600	First National Bank of Omaha	PDPM Webinar	Tom & Tara	Administrator	Woodstock, IL	27.50	
08/01/20	**6120-400600**	Durham Group	Executive Coaching and Team Development	Laundry Staff	Laundry	Woodstock, IL	550.00	
12/20/19	6120-400600	RH Sanders	Basic Life Support CPR	Laundry Staff	Laundry	Woodstock, IL	75.00	
09/15/20	6120-400600	First National Bank of Omaha	IHCA Annual Convention	Jen Boege	Laundry	Woodstock, IL	41.67	
08/01/20	**6130-400600**	Durham Group	Executive Coaching and Team Development	Housekeeping Staff	Housekeeping	Woodstock, IL	550.00	
12/02/19	6130-400600	RH Sanders	Basic Life Support CPR	Housekeeping Staff	Housekeeping	Woodstock, IL	30.00	
12/20/19	6130-400600	RH Sanders	Basic Life Support CPR	Housekeeping Staff	Housekeeping	Woodstock, IL	15.00	
02/12/20	6130-400600	Titan CPR Associates	Basic Life Support CPR	Housekeeping Staff	Housekeeping	Woodstock, IL	30.00	
09/15/20	6130-400600	First National Bank of Omaha	IHCA Annual Convention	Jen Boege	Housekeeping	Woodstock, IL	41.67	
08/01/20	**6140-400600**	Durham Group	Executive Coaching and Team Development	Dietary Staff	Dietary	Woodstock, IL	1,100.00	
02/12/20	6140-400600	Titan CPR Associates	Basic Life Support CPR	Dietary Staff	Dietary	Woodstock, IL	60.00	
09/15/20	6140-400600	First National Bank of Omaha	IHCA Annual Convention	Michael Azzani	Dietary	Woodstock, IL	83.33	
12/02/19	**6150-400600**	RH Sanders	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	360.00	
12/20/19	6150-400600	RH Sanders	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	270.00	
03/25/20	6150-400600	First National Bank of Omaha	HIN Tracking Clinical Conditions	Nursing Staff	Nursing	Woodstock, IL	129.00	
04/28/20	6150-400600	Rosie Connectivity	Web Training for Vitals Machines	Nursing Staff	Nursing	Woodstock, IL	500.00	
01/05/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	20.65	
02/12/20	6150-400600	Titan CPR Associates	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	510.00	
09/22/20	6150-400600	Titan CPR Associates	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	270.00	
12/03/19	6150-400600	Drake Lake Training	Performance Skills Recertification	Karina MedinaSalazar	Nursing	Woodstock, IL	150.00	
07/22/20	6150-400600	Drake Lake Training	Performance Skills Recertification	Henry Mionskowski	Nursing	Woodstock, IL	150.00	
08/01/20	6150-400600	Durham Group	Executive Coaching and Team Development	Nursing Staff	Nursing	Woodstock, IL	1,375.00	
03/03/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	15.71	
04/07/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	15.71	
05/05/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	18.33	
06/02/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	36.67	
07/07/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	27.50	
08/04/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	27.50	
09/01/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	27.50	
09/15/20	6150-400600	First National Bank of Omaha	IHCA Annual Convention	Nursing Staff	Nursing	Woodstock, IL	333.34	
10/06/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	27.50	
11/03/20	6150-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	55.00	
03/03/20	6150-400600	Redner, Dawn	APIC Conference	Dawn Redner	DON	Phoenix, AZ	685.00	ADJ
03/03/20	6150-400600	Judson, Meghan	APIC Conference	Meghan Judson	ADON	Phoenix, AZ	685.00	ADJ
06/03/20	6150-400600	Redner, Dawn	APIC Conference REFUND	Dawn Redner	DON	Phoenix, AZ	(685.00)	ADJ
06/08/20	6150-400600	Judson, Meghan	APIC Conference REFUND	Meghan Judson	ADON	Phoenix, AZ	(685.00)	ADJ
03/03/20	**6160-400600**	First National Bank of Omaha	HIN PDPM Webinar	Marissa	Therapy	Woodstock, IL	7.85	
02/04/20	6160-400600	First National Bank of Omaha	PDPM Webinar	Nursing Staff	Nursing	Woodstock, IL	13.75	
04/07/20	6160-400600	First National Bank of Omaha	HIN PDPM Webinar	Marissa	Therapy	Woodstock, IL	7.85	
07/07/20	6160-400600	First National Bank of Omaha	HIN PDPM Webinar	Marissa	Therapy	Woodstock, IL	27.50	
02/12/20	**6170-400600**	Titan CPR Associates	Basic Life Support CPR	Activties Staff	Activities	Woodstock, IL	90.00	
12/20/19	6170-400600	RH Sanders	Basic Life Support CPR	Activties Staff	Activities	Woodstock, IL	30.00	
09/22/20	6170-400600	Titan CPR Associates	Basic Life Support CPR	Activties Staff	Activities	Woodstock, IL	30.00	
FY2020	**6190-400600**	Relias Learning	In-house Webinar Courses	Staff	Staff	Woodstock, IL	5,460.00	
FY2020	6190-400600	Relias Learning	In-house Webinar Courses	Staff	Staff	Woodstock, IL	4,550.00	
							19937.00	

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $7,108**

(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. $ **65,234** 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. $ **277,478**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,437**

(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 Virchaw Kraus (not completed)**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.