



Facility Name & ID Number Valley Hi Nursing Home

# 0046821 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,441	16,342	9,529	43,312	8
9	SNF/PED					9
10	ICF	761	118		879	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,202	16,460	9,529	44,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.59%

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

None (Do not include bed-hold days in Section B.)

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

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

None

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

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

YES  NO

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

YES  NO

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

Date started 01/01/1956

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified 128 and days of care provided 4,519

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 11/30/2015 Fiscal Year: 11/30/2015

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

Facility Name &amp; ID Number

Valley Hi Nursing Home

# 0046821

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	509,765	42,322	11,635	563,722		563,722		563,722		1
2	Food Purchase		411,735		411,735		411,735	(11,008)	400,727		2
3	Housekeeping	289,668	54,308	4,539	348,515		348,515		348,515		3
4	Laundry	159,620	54,942		214,562		214,562		214,562		4
5	Heat and Other Utilities			148,043	148,043		148,043		148,043		5
6	Maintenance	98,953	510	126,368	225,831		225,831	(107)	225,724		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,058,006</b>	<b>563,817</b>	<b>290,585</b>	<b>1,912,408</b>		<b>1,912,408</b>	<b>(11,115)</b>	<b>1,901,293</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	3,465,299	306,361	3,813	3,775,473		3,775,473	(6,303)	3,769,170		10
10a	Therapy	76,560	4,055		80,615		80,615		80,615		10a
11	Activities	164,753	14,335	3,557	182,645		182,645		182,645		11
12	Social Services	211,558		2,707	214,265		214,265		214,265		12
13	CNA Training										13
14	Program Transportation			1,176	1,176		1,176		1,176		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,918,170</b>	<b>324,751</b>	<b>41,253</b>	<b>4,284,174</b>		<b>4,284,174</b>	<b>(6,303)</b>	<b>4,277,871</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	125,897			125,897		125,897		125,897		17
18	Directors Fees										18
19	Professional Services			18,144	18,144		18,144		18,144		19
20	Dues, Fees, Subscriptions & Promotions			18,764	18,764		18,764	(2,882)	15,882		20
21	Clerical & General Office Expenses	288,473	11,399	239,429	539,301		539,301	(145,818)	393,483		21
22	Employee Benefits & Payroll Taxes			2,509,014	2,509,014		2,509,014		2,509,014		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,794	11,794		11,794		11,794		24
25	Other Admin. Staff Transportation			5,975	5,975		5,975	(20)	5,955		25
26	Insurance-Prop.Liab.Malpractice			139,032	139,032		139,032		139,032		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>414,370</b>	<b>11,399</b>	<b>2,942,152</b>	<b>3,367,921</b>		<b>3,367,921</b>	<b>(148,720)</b>	<b>3,219,201</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,390,546</b>	<b>899,967</b>	<b>3,273,990</b>	<b>9,564,503</b>		<b>9,564,503</b>	<b>(166,138)</b>	<b>9,398,365</b>		<b>29</b>

\*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:

12/1/2014

Ending:

11/30/2015

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			522,853	522,853	522,853		522,853				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			260	260	260	(260)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,349	18,349	18,349		18,349				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			541,462	541,462	541,462	(260)	541,202				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		192,001	634,359	826,360	826,360		826,360				39
40	Barber and Beauty Shops			863	863	863		863				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,156	311,156	311,156	2,088	313,244				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		192,001	946,378	1,138,379	1,138,379	2,088	1,140,467				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,390,546	1,091,968	4,761,830	11,244,344	11,244,344	(164,310)	11,080,034				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: 12/1/2014

Ending: 11/30/2015

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,008)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,494)	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	(260)	32		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	(2,882)	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	(196,601)	21		24
25	Fund Raising, Advertising and Promotional	(4,517)	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	(4,417)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (226,179)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	61,869		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 61,869		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (164,310)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Valley Hi Nursing Home

ID# 0046821

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Polling Place Revenue	\$ (75)	21	1
2	Incontinence Care Reimbursement	(6,269)	10	2
3	Sale of Medical Records	(34)	10	3
4	Sale of Scrap	(107)	06	4
5	Provder Fee Adjustment - Occupancy Tax			5
6	applicable to the cost report period	2,088	42	6
7	Non-Allowable Transportation - Out of State	(20)	25	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	<b>Total</b>		(4,417)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Valley Hi Nursing Home

# 0046821

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,008)	0	0	0	0	0	0	0	0	0	0	(11,008)	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	(107)	0	0	0	0	0	0	0	0	0	0	(107)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(11,115)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,115)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,303)	0	0	0	0	0	0	0	0	0	0	(6,303)	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	<b>TOTAL Health Care and Programs</b>	<b>(6,303)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,303)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(2,882)	0	0	0	0	0	0	0	0	0	0	(2,882)	20
21	Clerical & General Office Expenses	(207,687)	61,869	0	0	0	0	0	0	0	0	0	(145,818)	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	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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	<b>TOTAL General Administration</b>	<b>(210,589)</b>	<b>61,869</b>	<b>0</b>	<b>(148,720)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(228,007)</b>	<b>61,869</b>	<b>0</b>	<b>(166,138)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Valley Hi Nursing Home# 0046821

Report Period Beginning:

12/1/2014 Ending:

Summary B

11/30/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	<b>TOTAL Ownership</b>	<b>(260)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(260)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	2,088	0	0	0	0	0	0	0	0	0	0	2,088	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>2,088</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,088</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(226,179)</b>	<b>61,869</b>	<b>0</b>	<b>(164,310)</b>	<b>45</b>								

**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.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 Computers	\$	McHenry County	100.00%	\$ 53,327	\$ 53,327	1
2	V	21 Office		McHenry County	100.00%	8,542	8,542	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 61,869	\$ * 61,869	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yvonne Barnes	BOD			McHenry County	Woodstock	County Govt.	1
2	Andrew Gasser	BOD						2
3	Anna May Miller	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	Carolyn Schofield	BOD						8
9	Joseph Gottemoller	BOD						9
10	Donald C. Kopsell	BOD						10
11	Nick Provenzano	BOD						11
12	Michael J. Walkup	BOD						12
13	Sue Draffkorn	BOD						13
14	John D. Hammerand	BOD						14
15	Bob Martens	BOD						15
16	Charles "Chuck" Wheeler	BOD						16
17	Tina Hill	BOD						17
18	John Jung, Jr.	BOD						18
19	Michael Skala	BOD						19
20	Michael Rein	BOD						20
21	Michele Avang	BOD						21
22	Diane Evertsen	BOD						22
23	Mary T. McCann	BOD						23
24	Larry W. Smith	BOD						24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$	1	
2										2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11										11	
12	See schedule 6-Supplemental for listing of County Board of Directors										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:

12/1/2014

Ending: 1/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<a href="#">Data Available from McHenry County upon Request</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									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Valley Hi Nursing Home

# 0046821

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
	<b>Working Capital</b>															
6	Avaya		X	Computers/Tech				547			260					
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$ 547			\$ 260					
	<b>B. Non-Facility Related*</b>															
10	Interest Income		X								(260)					
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (260)					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 547			\$					

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2014 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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:	2010	_____	8	<b>FOR BHF USE ONLY</b>		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
<b>Governmental Entity is Exempt from Paying Real Estate Taxes</b>				13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u>N/A</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
2.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
3.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
4.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
5.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
6.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
7.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
8.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
9.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
10.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
<b>TOTALS</b>			<u>\$</u>	<u>\$</u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Valley Hi Nursing Home

# 0046821 Report Period Beginning:

12/1/2014 Ending:

11/30/2015

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

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

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

Farm

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>435,600</u>	<u>1884</u>	<u>\$ 6,000</u>	1
2					2
3	<b>TOTALS</b>	<b>435,600</b>		<b>\$ 6,000</b>	<b>3</b>

Facility Name & ID Number Valley Hi Nursing Home

# 0046821

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	128	2006	2006	\$ 13,881,312	\$	40	\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Various		1988	15,629		20			
10	Various		1989	400,744		20			
11	Various		1994	21,235		20			
12	Various		1996	695,585		20			
13	Various		2006	25,425		20			
14	Various		2007	19,483		20			
15	Various		2008	80,862		20			
16	Various		2009	3,751		20			
17	Various		2010	120,395		20			
18	Various		2011	92,299		20			
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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:

12/1/2014

Ending:

11/30/2015

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Remodeling to Install New Door to Gravel Room	2012	\$ 7,240	\$	20	\$	\$	\$	37
38	Safety rails on Roof for Skylights	2012	6,665		20				38
39	Two Weil Submersible Sewage Pumps	2012	2,570		20				39
40	Two Doors and Hardware	2012	4,050		20				40
41	Myers Pump Repair	2012	2,899		20				41
42	Install Two ADA Ramps (Cut Curbs to make wheelchair access)	2012	4,580		20				42
43	Architect Svcs for Smoke Wall Remedial Repair	2013	3,723		20				43
44	Sidewalks - Concrete Leveling and Caulking	2013	11,504		20				44
45	Pond Irrigation Wiring	2013	4,107		20				45
46	Pond Irrigation Compressor	2013	3,500		20				46
47	Replaced Preaction Panel in Fire Alarm System	2013	2,631		20				47
48	Replaced Seven Iam's and one Riam in Fire System	2013	2,882		20				48
49	16 Additional Locks Master Rekeyed	2014	2,563		20				49
50	Master Rekey of Nursing Home	2014	5,214		20				50
51	IP Cameras (4) Additional	2014	7,552		20				51
52	Fiberglass 35,190 Underground	2014	24,000		20				52
53	Fiberglass 35,190 Gallon Underground	2014	24,000		20				53
54	Dock Door Frame	2015	2,530		20				54
55	DCEO Energy Efficiency Program	2015	210,063		20				55
56	Trane Chiller ("A/C") and Installation	2015	23,873		20				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	<b>Total Depreciation - Valley Hi Nursing Home</b>			<b>522,853</b>		<b>522,853</b>		<b>5,652,278</b>	<b>69</b>
70	<b>TOTAL (lines 4 thru 69)</b>		<b>\$ 15,712,866</b>	<b>\$ 522,853</b>		<b>\$ 522,853</b>	<b>\$</b>	<b>\$ 5,652,278</b>	<b>70</b>

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,092,251	\$	\$	\$	10	\$	71
72	Current Year Purchases	138,644				10		72
73	Fully Depreciated Assets							73
74	C/Y Dispositions	(9,639)						74
75	TOTALS	\$ 1,221,256	\$	\$	\$		\$	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		Tractor	1985	\$ 10,684	\$	\$	\$	5	\$	76
77		1999 Ford Bus	1999	40,035				5		77
78		2011 Chevy Equinox	2011	20,445				5		78
79										79
80	TOTALS			\$ 71,164	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 17,011,286	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 522,853	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 522,853	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,652,278	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	Construction in Progress	\$ 165,698	92
93			93
94			94
95		\$ 165,698	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: 12/1/2014

Ending: 11/30/2015

**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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 18,349 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**

**12/1/2014- 11/30/2015**

Page 14 Supplemental

<b>Description</b>	<b>Amount</b>
Photo Copier	12,370
Dish Machine	2,400
Dietary Equipment	3,460
Water Coolers	119
	<u>18,349</u>

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2014 Ending: 11/30/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	242,497	\$		\$	242,497	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				117,832				117,832	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				274,030				274,030	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-02	# of prescripts					143,252			143,252	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>See Attached</u>							48,749			48,749	12
13	Other (specify):											13
14	<b>TOTAL</b>			\$		\$	634,359	\$	192,001	\$	826,360	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.

<b><u>Special Services - Supplies (Line 12-Column 6 - Other) Amount</u></b>	
Medical Transport	1,346
Lab-Medicare	9,908
X-Rays Medicare Part A	6,360
Vaccine	5,960
Rental of Medical Equipment	21,192
Medical Services - Outpatient Pt. A	3,983
Total	<u>48,749</u>



Facility Name & ID Number Valley Hi Nursing Home# 0046821Report Period Beginning: 12/1/2014Ending: 11/30/2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2015 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 41,841,975	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>275,000</u> )	2,710,657		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	23,080		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,298,516		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 45,874,228	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,000		13
14	Buildings, at Historical Cost	14,379,241		14
15	Leasehold Improvements, at Historical Cost	1,223,669		15
16	Equipment, at Historical Cost	1,858,011		16
17	Accumulated Depreciation (book methods)	(5,652,278)		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): <u>See Attached</u>	165,698		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 11,980,341	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 57,854,569	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 135,484	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	547		29
30	Accrued Salaries Payable	501,467		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached</u>	1,909,814		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,547,312	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,547,312	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 55,307,257	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 57,854,569	\$	48

\*(See instructions.)

Line #	Other Current Assets:	Amount	Amount
9	Interest Receivable	22,946	
9	DOR-Contr.Sub To Ms Date(GASB68)	453,070	
9	DOR- Pensions(GASB 68)	822,500	
	Total Line 9	<u>1,298,516</u>	

Line #	Other Non-Current Assets:	Amount	Amount
23	Prepayment of Construction Project	165,698	
	Total Line 23	<u>165,698</u>	

Line #	Other Non-Current Assets:	Amount	Amount
36	Bed Tax Liability	110,791	
36	Due to HFS	1,299	
36	Due to General Fund	523	
36	Due to Employee Benefit Fund	115,949	
36	Due to Other Cnty. Depts.	209,093	
36	OPEB Liability	326,036	
36	Net Pension Liability (GASB 68)	1,146,123	
	Total Line 36	<u>1,909,814</u>	

Line #	Other Non-Current Assets:	Amount	Amount
43			
	Total Line 43	<u>                    </u>	

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>52,780,474</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>3</b>	<b>3</b>
<b>4</b>	<b>Restatement of Beginning FB - Chng. In Acctg. Principles</b>	<b>203,441</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>52,983,918</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,323,339</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>2,323,339</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>55,307,257</b>	<b>24</b> *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,199,659	1
2	Discounts and Allowances for all Levels	(2,164,564)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,035,095</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,220,957	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,220,957</b>	8
<b>C. Other Operating Revenue</b>			
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	10,986	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	126,459	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,638	19
20	Radiology and X-Ray	1,228	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 148,311</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,800	24
25	Interest and Other Investment Income***	79,422	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 82,222</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Attached	3,081,098	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,081,098</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,567,683</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,912,408	31
32	Health Care	4,284,174	32
33	General Administration	3,367,921	33
<b>B. Capital Expense</b>			
34	Ownership	541,462	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	827,223	35
36	Provider Participation Fee	311,156	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,244,344</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>2,323,339</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 2,323,339</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,013,366	44
45	Private Pay - Net Inpatient Revenue	2,950,476	45
46	Medicare - Net Inpatient Revenue	1,166,080	46
47	Other-(specify)	884,968	47
48	Other-(specify)	20,205	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 9,035,095</b>	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.

<b>Description</b>	<b>Amount</b>
Property Taxes	2,993,381
Real Estate Tax Dist. Interest	28
State Government Grants	81,182
Miscellaneous Income - Adj. 5A	22
Misc - Clerical - Adj. P5A	34
Rebates /Polling/Nursing/Maint. - Adj. P.5A	6,451
Total	<u>3,081,098</u>

Facility Name & ID Number Valley Hi Nursing Home

# 0046821

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,700	2,080	\$ 80,585	\$ 38.74	1
2	Assistant Director of Nursing	3,461	4,110	105,569	25.69	2
3	Registered Nurses	35,814	41,218	1,239,486	30.07	3
4	Licensed Practical Nurses	17,273	19,671	501,688	25.50	4
5	CNAs & Orderlies	92,989	104,943	1,410,901	13.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,377	4,231	76,560	18.09	8
9	Activity Director	1,821	2,160	45,052	20.86	9
10	Activity Assistants	9,613	10,937	119,701	10.94	10
11	Social Service Workers	7,410	8,489	211,558	24.92	11
12	Dietician					12
13	Food Service Supervisor	4,685	5,319	99,638	18.73	13
14	Head Cook	4,126	4,570	61,505	13.46	14
15	Cook Helpers/Assistants	5,866	6,745	87,884	13.03	15
16	Dishwashers	20,913	23,622	260,738	11.04	16
17	Maintenance Workers	3,160	3,826	98,953	25.86	17
18	Housekeepers	21,008	24,835	289,668	11.66	18
19	Laundry	11,500	13,157	159,620	12.13	19
20	Administrator	1,892	2,080	108,897	52.35	20
21	Assistant Administrator	536	560	17,000	30.36	21
22	Other Administrative	6,009	6,977	185,619	26.61	22
23	Office Manager					23
24	Clerical	5,968	7,047	102,854	14.59	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	1,654	1,957	43,594	22.27	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Supply/ Unit Clerk</u>	5,588	6,435	83,477	12.97	33
34	TOTAL (lines 1 - 33)	266,361	304,969	\$ 5,390,547 *	\$ 17.68	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	245	\$ 11,635	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant	14	962	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,851	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	3,557	11-03	44
45	Social Service Consultant	36	2,707	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	344	\$ 51,712		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Thomas Annarella	Administrator	0	\$ 108,897	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
Tara Goossens	Asst. Admin	0	17,000	Unemployment Compensation Insurance		Advertising: Employee Recruitment	6,822	
				FICA Taxes	412,314	Health Care Worker Background Check	740	
				Employee Health Insurance	1,379,890	(Indicate # of checks performed <u>75</u> )		
				Employee Meals		Patient Background Checks	105	
				Illinois Municipal Retirement Fund (IMRF)*	494,324	Subscriptions	1,082	
				Employee Physicals	6,500	Publications	479	
				Pension Expense	73,994	Licenses and Permits	1,090	
				Employee Relations	223	Dues	4,619	
				Sick Leave Buy Back	840			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 125,897				\$ 2,368,085		\$ 15,882		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$				\$			11,794	
C. Professional Services							Entertainment Expense	
Vendor/Payee	Type	Amount					( )	
Baker Tilly Virchow Kraus	Audit	\$ 8,000					TOTAL (agree to Sch. V, line 24, col. 8)	
FR&R	Consulting	980					\$ 11,794	
Episode Alert	Medicare Software	779						
FGMK	Cost Report/Consulting	8,385						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL				
\$ 18,144				\$				

\* Attach copy of IMRF notifications

\*\*See instructions.

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

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

Facility Name &amp; ID Number Valley Hi Nursing Home

# 0046821

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

## 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 \$7,296
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 66,333 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. \$ 313,244  
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. \$ 10,986
- (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 Tilley Virchow Krause
- (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.