

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0046821</u></p> <p>Facility Name: <u>Valley Hi Nursing Home</u></p> <p>Address: <u>2406 Hartland Road</u> <u>Woodstock</u> <u>60098</u> Number City Zip Code</p> <p>County: <u>McHenry</u></p> <p>Telephone Number: <u>(815) 338-0312</u> Fax # <u>(815) 338-0458</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/1956</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/2016</u> to <u>11/30/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1473 755 1661 950">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td data-bbox="1473 950 1661 1242">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u>
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<p>In the event there are further questions about this report, please contact: Name: <u>Andrew B. Cutler</u> Telephone Number: <u>(847) 374-0400</u> Email Address: _____</p>	<p>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</p>																												

Facility Name & ID Number Valley Hi Nursing Home

0046821 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,518	13,148	8,549	41,215	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,518	13,148	8,549	41,215	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.22%

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

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 1/1/1956

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 4,808

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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: 12/1/2016 Ending: 11/30/2017

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
	A. General Services										
1	Dietary	509,099	32,896	10,864	552,859		552,859		552,859		1
2	Food Purchase		442,809		442,809		442,809	(10,341)	432,468		2
3	Housekeeping	302,760	57,715	1,645	362,120		362,120		362,120		3
4	Laundry	163,481	51,962		215,443		215,443		215,443		4
5	Heat and Other Utilities			137,955	137,955		137,955		137,955		5
6	Maintenance	101,728	609	214,439	316,776		316,776	(174)	316,602		6
7	Other (specify):*										7
8	TOTAL General Services	1,077,068	585,991	364,903	2,027,962		2,027,962	(10,515)	2,017,447		8
	B. Health Care and Programs										
9	Medical Director			35,800	35,800		35,800		35,800		9
10	Nursing and Medical Records	3,413,008	234,092	201,451	3,848,551		3,848,551	(5,610)	3,842,941		10
10a	Therapy	88,426	1,543		89,969		89,969		89,969		10a
11	Activities	171,309	14,969	4,895	191,173		191,173		191,173		11
12	Social Services	216,894		4,148	221,042		221,042		221,042		12
13	CNA Training										13
14	Program Transportation			642	642		642		642		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,889,637	250,604	246,936	4,387,177		4,387,177	(5,610)	4,381,567		16
	C. General Administration										
17	Administrative	182,038			182,038		182,038		182,038		17
18	Directors Fees										18
19	Professional Services			17,063	17,063		17,063		17,063		19
20	Dues, Fees, Subscriptions & Promotions			20,092	20,092		20,092	(3,337)	16,755		20
21	Clerical & General Office Expenses	300,564	13,389	432,445	746,398		746,398	(331,465)	414,933		21
22	Employee Benefits & Payroll Taxes			2,862,414	2,862,414		2,862,414		2,862,414		22
23	Inservice Training & Education			3,931	3,931		3,931		3,931		23
24	Travel and Seminar			11,550	11,550		11,550		11,550		24
25	Other Admin. Staff Transportation			8,072	8,072		8,072	(603)	7,469		25
26	Insurance-Prop.Liab.Malpractice			245,555	245,555		245,555		245,555		26
27	Other (specify):*										27
28	TOTAL General Administration	482,602	13,389	3,601,122	4,097,113		4,097,113	(335,405)	3,761,708		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,449,307	849,984	4,212,961	10,512,252		10,512,252	(351,530)	10,160,722		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Valley Hi Nursing Home
0046821
Supplemental Travel Schedule
12/1/2016-11/30/2017

EMPLOYEE	JOB	PURPOSE			Events					
DATE	NAME	DESCRIPTION	DESTINATION	OF TRIP	MILEAGE	FOOD	Reimbursement	Train/Cab/Tolls/Park	HOTEL	TOTAL
12/1/16 - 1	Thomas Annarella	Administrator	Springfield, IL	IHCA Board of Directors Meeting	1,562.69			17.00	114.24	1,693.93
9/14/17	Thomas Annarella	Administrator	Peoria, IL	IHCA Annual Convention	192.60				739.45	932.05
9/14/17	Deb Weber	Social Services Asst	Wheaton, IL	Wyndemere Senior Living Seminar	33.12					33.12
9/14/17	Deborah Huml	Socoal Services	Peoria, IL	IHCA Annual Convention		100.90				100.90
1/11/17	Thomas Annarella	Administrator	Springfield, IL	IHCA Public Policy Forum					122.08	122.08
7/31/17	Thomas Annarella	Administrator	Woodstock, IL	Emergency Planning Committee - Pizza		74.59				74.59
8/25/17	Thomas Annarella	Administrator	Woodstock, IL	Planning Committee - Pizza		55.99				55.99
9/14/17	Thomas Annarella	Administrator	Peoria, IL	IHCA Annual Convention					918.85	918.85
9/14/17	Thomas Annarella	Administrator	Springfield, IL	IHCA Board of Directors Meeting					149.16	149.16
5/15/17	Thomas Annarella	Administrator	Nashville, TN	AHCA NCAL 67th Annual Convention Expo missed invoice					602.50	602.50
TOTAL FOR ADMIN ACCT #'s					1,788.41	231.48	0.00	17.00	2,646.28	4,683.17
					610010-5040-10	610010-5050-10	610010-5050-30	610010-5050-40	610010-5050-20	
2/28/17	Paulette Washay	Dietary	Kenosha, WI	GFS Outcome Through Nutrition Seminar	58.74					58.74
3/14/17	Paulette Washay	Dietary	Milwaukee, WI	Food Exp	86.88			16.00		102.88
3/15/17	Paulette Washay	Dietary	Rosemont, IL	GFS Food Expo	51.57			15.00		66.57
TOTAL FOR DIETARY ACCT #'s					197.19	0.00	0.00	31.00	0.00	228.19
					610040-5040-10	610040-5050-10	610040-5050-30	610040-5050-40	610040-5050-20	
9/14/17	Dawn Redner	Nursing	Peoria, IL	IHCA Annual Convention		53.12			369.73	422.85
9/14/17	Heather Harmon	Nursing	Peoria, IL	IHCA Annual Convention	179.23	65.78				245.01
8/17/17	Meghan Judson	Nursing	Milwaukee, WI	APIC EPI Intensive Course	86.99	106.76		72.00	686.00	951.75
9/14/17	Meghan Judson	Nursing	Peoria, IL	IHCA Annual Convention		78.26				78.26
5/16/17	Dawn Redner	Nursing	Arlington Heights, IL	Pharmacology Seminar	78.27					78.27
3/30/17	Dawn Redner	Nursing	Arlington Heights, IL	PESI Patient & License Safety Seminar	78.27					78.27
10/6/17	Dawn Redner	Nursing	Naperville, IL	Long Term Care Survey Process	91.49					91.49
9/15/17	Meghan Judson	Nursing	Peoria, IL	IHCA Annual Convention					739.45	739.45
TOTAL FOR NURSING ACCT #'s					514.25	303.92	0.00	72.00	1,795.18	2,685.35
					610050-5040-10	610050-5050-10	610050-5050-30	610050-5050-40	610050-5050-20	
9/14/17	Linda Barrett	Activities	Peoria, IL	IHCA Annual Convention		48.00			369.72	417.72
5/3/17	Deb Weber	Activities	Naperville, IL	Activity Assistant Training	37.18					37.18
7/19/17	Erin Eiserman	Activities	Naperville, IL	Hebron, IL	13.96					13.96
6/14/17	Erin Eiserman	Activities	Naperville, IL	Woodstock, IL	8.19					8.19
TOTAL FOR ACTIVITY ACCT #'s					59.33	48.00	0.00	0.00	369.72	477.05
					610070-5040-10	610070-5050-10	610070-5050-30	610070-5050-40	610070-5050-20	

ADJ

Facility Name & ID Number

Valley Hi Nursing Home

#0046821

Report Period Beginning:

12/1/2016

Ending:

11/30/2017

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	
	D. Ownership											
30	Depreciation			551,531	551,531		551,531		551,531			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			31,603	31,603		31,603		31,603			35
36	Other (specify):*											36
37	TOTAL Ownership			583,134	583,134		583,134		583,134			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		192,067	720,214	912,281		912,281		912,281			39
40	Barber and Beauty Shops		839		839		839		839			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			291,072	291,072		291,072		291,072			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		192,906	1,011,286	1,204,192		1,204,192		1,204,192			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,449,307	1,042,890	5,807,381	12,299,578		12,299,578	(351,530)	11,948,048			45

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

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	(10,341)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,356)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,337)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(357,956)	21		24
25	Fund Raising, Advertising and Promotional	(7,215)	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	(6,537)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (395,742)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (395,742)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Valley Hi Nursing Home

ID# 0046821

Report Period Beginning: 12/1/2016

Ending: 11/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Polling Place Revenue	\$ (150)	21	1
2	Medical Records Revenue	(251)	10	2
3	Scrap Revenue	(174)	6	3
4	Offset Rebate Medical	(5,359)	10	4
5	Out of State Travel	(603)	25	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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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	(6,537)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Valley Hi Nursing Home

0046821

Report Period Beginning:

12/1/2016

Ending:

11/30/2017

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	(10,341)	0	0	0	0	0	0	0	0	0	0	(10,341)	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	(174)	0	0	0	0	0	0	0	0	0	0	(174)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,515)	0	0	0	0	0	0	0	0	0	0	(10,515)	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	(5,610)	0	0	0	0	0	0	0	0	0	0	(5,610)	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	(5,610)	0	0	0	0	0	0	0	0	0	0	(5,610)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,337)	0	0	0	0	0	0	0	0	0	0	(3,337)	20
21	Clerical & General Office Expenses	(375,677)	44,212	0	0	0	0	0	0	0	0	0	(331,465)	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	(603)	0	0	0	0	0	0	0	0	0	0	(603)	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	(379,617)	44,212	0	(335,405)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(395,742)	44,212	0	(351,530)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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)	(395,742)	44,212	0	(351,530)	45								

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Computers	\$	McHenry County		\$ 35,670	\$ 35,670	1
2	V	21 Office		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		\$			\$ 44,212	\$ * 44,212	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 Governmen	1
2	Christopher Spoerl	BOD						2
3	Thomas Wilbeck	BOD						3
4	Robert "Bob" Nowak	BOD						4
5	James L. Heisler	BOD						5
6	Jeffrey Thorsen	BOD						6
7	Donna Kurtz	BOD						7
8	John Reinert	BOD						8
9	Joseph Gottemoller	BOD						9
10	Donald C. Kopsell	BOD						10
11	Chris Christensen	BOD						11
12	Michael J. Walkup	BOD						12
13	Kay R. Bates	BOD						13
14	John D. Hammerand	BOD						14
15	Craig Wilcox	BOD						15
16	Charles "Chuck" Wheeler	BOD						16
17	Paula Yensen	BOD						17
18	John Jung, Jr.	BOD						18
19	Michael Skala	BOD						19
20	Michael Rein	BOD						20
21	Michele Aavang	BOD						21
22	Jim Kearns	BOD						22
23	Mary T. McCann	BOD						23
24	Larry W. Smith	BOD						24
25	Jack D. Franks	BOD						25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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										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:

12/1/2016

Ending: 1/30/2017

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

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	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	Data Available From McHenry County Upon Request				\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Valley Hi Nursing Home

0046821

Report Period Beginning:

12/1/2016

Ending:

11/30/2017

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

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 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 2017 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:	2012	<u> </u>	8
	2013	<u> </u>	9
	2014	<u> </u>	10
	2015	<u> </u>	11
	2016	<u> </u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

County operated entity does not pay real estate tax

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 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 2016 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 2016.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

12/1/2016 Ending:

11/30/2017

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).

None

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:

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

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	\$ 347,033	\$ 347,033	\$ 3,865,697
5									
6									
7									
8									
Improvement Type**									
9	Various		1988	15,629		20			15,629
10	Various		1989	400,744		20			400,744
11	Various		1994	21,235		20			21,235
12	Various		1996	695,585		20			695,585
13	Various		2006	25,425		20			25,425
14	Various		2007	19,483		20	974	974	9,740
15	Various		2008	80,862		20	4,043	4,043	8,078
16	Various		2009	3,751		20	188	188	1,504
17	Various		2010	120,395		20	6,020	6,020	42,140
18	Various		2011	92,299		20	4,615	4,615	27,690
19	Various		2012	28,004		20	1,400	1,400	7,000
20	Various		2013	28,347		14	2,792	2,792	11,890
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35	Current Book Depreciation				551,531			(551,531)	
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:

12/1/2016 Ending: 11/30/2017

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	16 Additional Locks Master Rekeyed	2014	\$ 2,563	\$	10	\$ 256	\$ 256	\$ 918	37
38	Master Rekey of Nursing Home	2014	5,214		10	521	521	1,867	38
39	IP Cameras (4) Additional	2014	7,552		10	755	755	2,517	39
40	Fiberglass 35,190 Underground	2014	24,000		15	1,600	1,600	5,200	40
41	Fiberglass 35,190 Gallon Underground	2014	24,000		15	1,600	1,600	5,200	41
42	Dock Door Frame	2015	2,530		10	253	253	548	42
43	DCEO Energy Efficiency Program	2015	210,063		20	10,503	10,503	29,333	43
44	Architect: Flooring Nurses Stations/ Halls	2016	13,600		10	1,360	1,360	1,813	44
45	Flooring Laminate: Nurses Stations/ Halls	2016	168,599		10	16,860	16,860	22,480	45
46	Sealcoat, Repair and re-stripe parking lot	2016	37,061		10	3,706	3,706	4,015	46
47	Irrigation repairs	2017	3,612		7	215	215	215	47
48	Pond liner repairs	2017	5,913		15	33	33	33	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,917,778	\$ 551,531		\$ 404,728	\$ (146,803)	\$ 5,206,497	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:

12/1/2016

Ending:

11/30/2017

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	\$ 1,445,238	\$	\$ 146,803	\$ 146,803		\$ 1,207,066	71
72	Current Year Purchases	78,054						72
73	Fully Depreciated Assets							73
74	Disposals	(43,270)						74
75	TOTALS	\$ 1,480,022	\$	\$ 146,803	\$ 146,803		\$ 1,207,066	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 Ford Bus	1999	\$ 40,035	\$	\$	\$	5	\$ 40,035	76
77		2011 Chevy Equinox Car	2011	20,445				5	20,445	77
78		Tractor	1985	10,684				5	10,684	78
79										79
80	TOTALS			\$ 71,164	\$	\$	\$		\$ 71,164	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,474,964	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 551,531	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 551,531	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)	\$ 6,484,727	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	Prepayment on Construction P	\$ 12,325	92
93			93
94			94
95		\$ 12,325	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: 12/1/2016

Ending: 11/30/2017

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 31,603 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

Page 14 Supplemental

Description	Amount
Photo Copier	12,346
Dish Machine	2,400
Water Coolers	119
Tents for Resident Picnic	3,580
Tables for Resident Picnic	600
Chairs for Resident Picnic	330
Cotton Candy Machine	88
Hand Washing stations for Resident Picnic	140
Avaya Telephone Equipment	12,000
	<u>31,603</u>

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 265,823	\$		\$ 265,823	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			120,737			120,737	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			333,654			333,654	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				147,418		147,418	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Attached</u>	39-2					44,649		44,649	13
14	TOTAL			\$		\$ 720,214	\$ 192,067		\$ 912,281	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	10,730
X-Rays Medicare Part A	6,422
Rental of Medical Equipment	25,111
Medical Services - Outpatient Pt. A	2,276
Medical Transport	110
Total	<u>44,649</u>

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11/30/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 28,612,396	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (425,000))	3,503,989		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	26,777		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	13,180,014		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 45,323,176	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,000		13
14	Buildings, at Historical Cost	14,561,440		14
15	Leasehold Improvements, at Historical Cost	1,270,255		15
16	Equipment, at Historical Cost	2,092,904		16
17	Accumulated Depreciation (book methods)	(6,484,727)		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>	12,325		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,458,197	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 56,781,373	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 194,237	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	440,600		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	<u>See Attached</u>	431,078		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,065,915	\$	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	<u>See Attached</u>	3,075,904		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,075,904	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,141,819	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 52,639,552	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 56,781,371	\$	48

*(See instructions.)

Line #	Other Current Assets:	Amount	Amount
9	Interest Receivable	111,777	
9	DOR- Pensions(GASB 68)	454,373	
9	Property Tax Receivable	10,000	
9	DIR-Pensions (GASB68)	(346,697)	
9	DOR-Contr.Sub to Ms Date (GASB68)	1,423,076	
9	Investments	11,527,485	
	Total Line 9	<u>13,180,014</u>	

Line #	Other Non-Current Assets:	Amount	Amount
23	Prepayment on Construction Project	12,325	
	Total Line 23	<u>12,325</u>	

Line #	Other Non-Current Liabilities:	Amount	Amount
36	Bed Tax Liability	81,830	
36	Due to HFS	45,988	
36	Due to General Fund	330	
36	Due to Employee Benefit Fund	116,897	
36	Due to Other Cnty. Depts.	161,055	
36	Deferred Interest Revenue	14,978	
36	Deferred Property Tax Revenue	10,000	
	Total Line 36	<u>431,078</u>	

Line #	Other Non-Current Liabilities:	Amount	Amount
43	OPEB Liability	512,738	
43	Net Pension Liability (GASB 68)	2,430,475	
43	Compensated Absences Payable	132,691	
	Total Line 43	<u>3,075,904</u>	

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 53,950,920	1
2	Restatements (describe):		2
3	Restatement of Beginning FB-Chg. In Accounting Principal	203,441	3
4	Correction of PY Equity	(308,610)	4
5	Rounding	(2)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 53,845,749	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,206,197)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,206,197)	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)	\$ 52,639,552	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Valley Hi Nursing Home

0046821

Report Period Beginning: 12/1/2016

Ending: 11/30/2017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,858,627	1
2	Discounts and Allowances for all Levels	(2,024,869)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,833,758	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,334,502	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,334,502	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	10,341	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	131,502	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,342	19
20	Radiology and X-Ray	4,123	20
21	Other Medical Services	545	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 156,853	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	752,354	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 752,354	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc. Income (Adj P. 5)	15,914	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,914	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,093,381	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,027,962	31
32	Health Care	4,387,177	32
33	General Administration	4,097,113	33
B. Capital Expense			
34	Ownership	583,134	34
C. Ancillary Expense			
35	Special Cost Centers	913,120	35
36	Provider Participation Fee	291,072	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,299,578	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,206,197)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,206,197)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,722,580	44
45	Private Pay - Net Inpatient Revenue	3,130,170	45
46	Medicare - Net Inpatient Revenue	1,333,355	46
47	Other-(specify) <u>Insurance</u>	13,120	47
48	Other-(specify) <u>Hospice</u>	634,533	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,833,758	49

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

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

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

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

Facility Name & ID Number Valley Hi Nursing Home

0046821

Report Period Beginning: 12/1/2016

Ending: 11/30/2017

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	1,408	2,080	\$ 84,587	\$ 40.67	1
2	Assistant Director of Nursing	3,447	4,160	132,158	31.77	2
3	Registered Nurses	33,569	38,511	1,215,071	31.55	3
4	Licensed Practical Nurses	18,314	21,673	570,564	26.33	4
5	CNAs & Orderlies	78,000	88,205	1,215,213	13.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,491	4,554	88,426	19.42	8
9	Activity Director	1,968	2,242	49,478	22.07	9
10	Activity Assistants	9,319	10,646	121,831	11.44	10
11	Social Service Workers	7,487	8,489	216,894	25.55	11
12	Dietician					12
13	Food Service Supervisor	4,454	5,116	98,922	19.34	13
14	Head Cook	4,807	5,412	74,071	13.69	14
15	Cook Helpers/Assistants	5,564	6,457	85,385	13.22	15
16	Dishwashers	19,704	22,194	250,721	11.30	16
17	Maintenance Workers	2,945	3,827	101,728	26.58	17
18	Housekeepers	17,863	21,437	302,760	14.12	18
19	Laundry	13,027	14,646	163,481	11.16	19
20	Administrator	1,956	2,080	111,967	53.83	20
21	Assistant Administrator	1,875	2,080	70,071	33.69	21
22	Other Administrative	7,793	9,322	245,461	26.33	22
23	Office Manager					23
24	Clerical	4,536	5,053	55,103	10.91	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	1,661	1,965	46,058	23.44	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Supply/Unit Clerk</u>	9,561	11,189	149,357	13.35	33
34	TOTAL (lines 1 - 33)	252,749	291,338	\$ 5,449,307 *	\$ 18.70	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	229	\$ 10,864	1-3	35
36	Medical Director	Monthly	35,800	9-3	36
37	Medical Records Consultant	14	1,019	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	66	4,895	11-3	44
45	Social Service Consultant	55	4,148	12-3	45
46	Other(specify)				46
47	<u>Dental Services</u>	Monthly	36,805	10-3	47
48					48
49	TOTAL (lines 35 - 48)	364	\$ 95,067		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	346	\$ 16,849	10-3	50
51	Licensed Practical Nurses	1,375	61,848	10-3	51
52	Certified Nurse Assistants/Aides	1,834	47,230	10-3	52
53	TOTAL (lines 50 - 52)	3,555	\$ 125,927		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%	\$ 111,967	Workers' Compensation Insurance	\$	IDPH License Fee	\$		
Tara Goossens	Asst. Admin.	0%	70,071	Unemployment Compensation Insurance		Advertising: Employee Recruitment	200		
				FICA Taxes	415,870	Health Care Worker Background Check (Indicate # of checks performed <u>26</u>)	880		
				Employee Health Insurance	1,429,854	Patient Background Checks <u>90</u>	900		
				Employee Meals		Subscriptions	1,038		
				Illinois Municipal Retirement Fund (IMRF)*	506,175	Permits	1,480		
				Employee Physicals	9,150	Dues	11,831		
				Pension Expense	499,886	Classified Ads	51		
				Employee Relations	600	Publications	375		
				Sick Leave Buy-Back	879	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 182,038	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,862,414	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,755
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)			\$				Seminar Expense	11,550	
C. Professional Services									
Vendor/Payee	Type	Amount							
Baker Tilly/ Virchow Kraus	Audit	\$ 7,850					Entertainment Expense ()		
FGMK, LLC	Cost Report/Consulting	8,435					TOTAL (agree to Sch. V, line 24, col. 8)		\$ 11,550
Episode Alert	Medicare Software	778							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 17,063	TOTAL					

* Attach copy of IMRF notifications

**See instructions.

DATE	G/L ACCT#	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
08/09/17	610010-4006-10	Elderwerks	Understanding Decisional Capacity	Deb Weber	Social Services Asst	Arlington Heights, IL	15.00
01/03/17	610010-4006-10	First National Bank of Omaha	IHCA Public Policy Forum	Thomas Annarella	Administrator	Springfield, IL	30.00
01/10/17	610010-4006-10	First National Bank of Omaha	Challenging Geriatric Behavior	Deborah Huml	Social Services	Arlington Heights, IL	199.99
01/24/17	610010-4006-10	First National Bank of Omaha	Review Course for IL Licensure Exam	Tara Goossens	Asst Administrator	Lisle, IL	395.00
08/19/17	610010-4006-10	First National Bank of Omaha	IHCA Annual Convention	Admin Staff	Administration	Peoria, IL	340.71
09/29/17	610010-4006-10	First National Bank of Omaha	Long Term Care Survery Process	Deborah Huml	Social Services	Naperville, IL	249.00
09/01/17	610010-4006-30	Durham Group	Executive Coaching and Team Development	Thomas Annarella	Administrator	Woodstock, IL	208.34
09/01/17	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tammy Schultz	Payroll	Woodstock, IL	208.34
09/01/17	610010-4006-30	Durham Group	Executive Coaching and Team Development	Deborah Huml	Social Services	Woodstock, IL	208.34
09/01/17	610010-4006-30	Durham Group	Executive Coaching and Team Development	Sharon Chewning	Nurse Liason	Woodstock, IL	208.34
09/01/17	610010-4006-30	Durham Group	Executive Coaching and Team Development	Tara Goossens	Asst Administrator	Woodstock, IL	1,458.33
02/10/17	610010-4006-30	First National Bank of Omaha	Social Work & Activities Dept Compliance	Tom, Tara, & Deborah	Admin Staff	Woodstock, IL	96.75
03/02/17	610010-4006-30	First National Bank of Omaha	5 Star Survey Webinar	Thomas Annarella	Administrator	Woodstock, IL	55.00
03/09/18	610010-4006-30	First National Bank of Omaha	How to Supervise Bad Attitudes & Negative Behavior	Thomas Annarella	Administrator	Woodstock, IL	99.00
05/23/17	610010-4006-30	First National Bank of Omaha	5 Star Pain Quality Measures & Applying QAPI Principles	Thomas Annarella	Administrator	Woodstock, IL	55.00
05/23/17	610010-4006-30	First National Bank of Omaha	Self Directed Dining	Tara Goossens	Asst Administrator	Woodstock, IL	64.50
09/23/17	610010-4006-30	First National Bank of Omaha	MDS Changes Webinar	Tom, Tara, & Deborah	Admin Staff	Woodstock, IL	77.40
06/19/17	610020-4006-30	Murray, Cristina	Basic Life Support CPR	Laundry Staff	Laundry	Woodstock, IL	50.00
09/01/17	610020-4006-30	Durham Group	Executive Coaching and Team Development	Chuck Martens	Laundry	Woodstock, IL	104.17
11/26/17	610030-4006-30	Murray, Cristina	Basic Life Support CPR	Housekeeping Staff	Housekeeping	Woodstock, IL	80.00
06/19/17	610030-4006-30	Murray, Cristina	Basic Life Support CPR	Housekeeping Staff	Housekeeping	Woodstock, IL	10.00
09/01/17	610030-4006-30	Durham Group	Executive Coaching and Team Development	Chuck Martens	Housekeeping	Woodstock, IL	104.16
11/26/17	610040-4006-30	Murray, Cristina	Basic Life Support CPR	Dietary Staff	Dietary	Woodstock, IL	20.00
09/01/17	610040-4006-30	Durham Group	Executive Coaching and Team Development	Patrick Jansen	Dietary	Woodstock, IL	208.33
09/01/17	610040-4006-30	Durham Group	Executive Coaching and Team Development	Paulette Washay	Dietary	Woodstock, IL	208.33
05/23/17	610040-4006-30	First National Bank of Omaha	Self Directed Dining	Paulette Washay	Dietary	Woodstock, IL	64.50
02/27/17	610050-4006-10	First National Bank of Omaha	APIC EPI Intensive	Meghan Judson	ADON	Milwaukee, WI	1,125.00
02/27/17	610050-4006-10	First National Bank of Omaha	PESI Pharmacology Seminar	Meghan Judson	ADON	Arlington Heights, IL	199.99
02/27/17	610050-4006-10	First National Bank of Omaha	PESI Pharmacology Seminar	Dawn Redner	DON	Arlington Heights, IL	199.99
02/27/17	610050-4006-10	First National Bank of Omaha	Nursing Documentation	Meghan Judson	ADON	Arlington Heights, IL	199.99
02/27/17	610050-4006-10	First National Bank of Omaha	Nursing Documentation	Dawn Redner	DON	Arlington Heights, IL	199.99
05/31/17	610050-4006-10	First National Bank of Omaha	IL Summit Antimicrobial Stewardship	Meghan Judson	ADON	Naperville, IL	39.00
08/19/17	610050-4006-10	First National Bank of Omaha	IHCA Annual Convention	Nursing Staff	Nursing	Peoria, IL	430.72
09/29/17	610050-4006-10	First National Bank of Omaha	Long Term Care Survery Process	Dawn Redner	DON	Naperville, IL	249.00
11/26/17	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	80.00
06/19/17	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	60.00
05/09/17	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	200.00
01/22/17	610050-4006-30	Murray, Cristina	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	40.00
09/01/17	610050-4006-30	Durham Group	Executive Coaching and Team Development	Dawn Redner	DON	Woodstock, IL	1,458.33
09/01/17	610050-4006-30	Durham Group	Executive Coaching and Team Development	Meghan Judson	ADON	Woodstock, IL	208.33
09/01/17	610050-4006-30	Durham Group	Executive Coaching and Team Development	Heather Harmon	ADON	Woodstock, IL	208.33
09/23/17	610050-4006-30	First National Bank of Omaha	MDS Changes Webinar	Beth & Meghan	Nursing	Woodstock, IL	51.60
11/17/17	610050-4006-30	Wingate RN Training	Resident Attendant Feeding Course	Nursing Staff	Nursing	Woodstock, IL	1,208.00
05/02/17	610070-4006-10	First National Bank of Omaha	Activity Assistant Workshop	Deb Weber	Activities	Naperville, IL	79.00
05/02/17	610070-4006-10	First National Bank of Omaha	Activity Assistant Workshop	Pauline McCollum	Activities	Naperville, IL	79.00
08/19/17	610070-4006-10	First National Bank of Omaha	IHCA Annual Convention	Linda Barrett	Activities	Peoria, IL	113.57
01/22/17	610070-4006-30	Murray, Cristina	Basic Life Support CPR	Activities Staff	Activities	Woodstock, IL	60.00
09/01/17	610070-4006-30	Durham Group	Executive Coaching and Team Development	Linda Barrett	Activities	Woodstock, IL	208.33
02/10/17	610070-4006-30	First National Bank of Omaha	Social Work & Activities Dept Compliance	Linda Barrett	Activities	Woodstock, IL	32.25
							11548.95

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$8448
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,240 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. \$ 291,072
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,341
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
 - d. Have vehicle usage logs been maintained? No
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Baker Tilly Virchow Kraus
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees