

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0046821

Facility Name: Valley Hi Nursing Home

Address: 2406 Hartland Road Woodstock 60098

County: McHenry

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

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

XGOVERNMENTAL

State

XCounty

Other

In the event there are further questions about this report, please contact:

Name: Andrew B. Cutler

Telephone Number: (847) 940-3269

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2024 to 11/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Print Name and Title) Andrew B. Cutler Managing Director, Healthcare

(Firm Name & Address) FGMK, LLC 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015

(Telephone) (847) 940-3269 Fax #: (847) 964-5469

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

Facility Name & ID Number Valley Hi Nursing Home # 0046821 Report Period Beginning: 12/1/2024 Ending: 11/30/2025

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	<u>128</u>	Skilled (SNF)	<u>124</u>	<u>45,948</u>	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	<u>128</u>	TOTALS	<u>124</u>	<u>45,948</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	8,490	7,338	199	16	8,374	4,856	1,676	30,949	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	8,490	7,338	199	16	8,374	4,856	1,676	30,949	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 67.36%

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 certified beds. number of certified beds 128

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: 11/30/2025 Fiscal Year: 11/30/2025

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	809,023	31,404	10,406	850,833		850,833		850,833			1
2	Food Purchase		470,199		470,199		470,199	(2,589)	467,610			2
3	Housekeeping	396,658	57,720		454,378		454,378		454,378			3
4	Laundry	215,581	33,963		249,544		249,544		249,544			4
5	Heat and Other Utilities			192,776	192,776		192,776		192,776			5
6	Maintenance	117,836	6,510	209,652	333,998		333,998	(223)	333,775			6
7	Other (specify):*											7
8	TOTAL General Services	1,539,098	599,796	412,834	2,551,728		2,551,728	(2,812)	2,548,916			8
	B. Health Care and Programs											
9	Medical Director			47,500	47,500		47,500		47,500			9
10	Nursing and Medical Records	5,761,628	358,314	417,051	6,536,993		6,536,993	(103)	6,536,890			10
10a	Therapy	236,825	1,991		238,816		238,816		238,816			10a
11	Activities	244,645	10,741	1,040	256,426		256,426		256,426			11
12	Social Services	127,777		1,040	128,817		128,817		128,817			12
13	CNA Training			1,678	1,678		1,678		1,678			13
14	Program Transportation			983	983		983		983			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,370,875	371,046	469,292	7,211,213		7,211,213	(103)	7,211,110			16
	C. General Administration											
17	Administrative	268,080			268,080		268,080		268,080			17
18	Directors Fees											18
19	Professional Services			31,363	31,363		31,363		31,363			19
20	Dues, Fees, Subscriptions & Promotions			68,010	68,010		68,010	(3,626)	64,384			20
21	Clerical & General Office Expenses	591,459	14,086	460,196	1,065,741		1,065,741	1,014,394	2,080,135			21
22	Employee Benefits & Payroll Taxes			3,911,692	3,911,692		3,911,692		3,911,692			22
23	Inservice Training & Education			3,190	3,190		3,190		3,190			23
24	Travel and Seminar			35,647	35,647		35,647	(900)	34,747			24
25	Other Admin. Staff Transportation			4,591	4,591		4,591	(1,617)	2,974			25
26	Insurance-Prop.Liab.Malpractice			413,962	413,962		413,962		413,962			26
27	Other (specify):*											27
28	TOTAL General Administration	859,539	14,086	4,928,651	5,802,276		5,802,276	1,008,251	6,810,527			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,769,512	984,928	5,810,777	15,565,217		15,565,217	1,005,336	16,570,553			29

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

FACILITY NAME: Valley Hi Nursing Home
LINE 25 - SUPPLEMENTAL SCHEDULE
FYE: 12/1/2024-11/30/2025

[illegible]

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			667,636	667,636		667,636		667,636			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110	110		110	(110)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,794	15,794		15,794		15,794			35
36	Other (specify):*											36
37	TOTAL Ownership			683,540	683,540		683,540	(110)	683,430			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		373,519	731,636	1,105,155		1,105,155		1,105,155			39
40	Barber and Beauty Shops		841		841		841		841			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,048	181,048		181,048	(21,182)	159,866			42
43	Other (specify):* Loss on Disposal of F/A			5,409	5,409		5,409		5,409			43
44	TOTAL Special Cost Centers		374,360	918,093	1,292,453		1,292,453	(21,182)	1,271,271			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	8,769,512	1,359,288	7,412,410	17,541,210		17,541,210	984,044	18,525,254			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,589)	02		4
5	Telephone, TV & Radio in Resident Rooms	(15,210)	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	(110)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(294,460)	21		24
25	Fund Raising, Advertising and Promotional	(6,415)	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	(27,651)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (346,435)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,330,479		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,330,479		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 984,044		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(3,366)	20	2
3	Ofset Maintenance Revenue	(223)	06	3
4	Offset Medical revenue/rebates	(103)	10	4
5	Non-Allowable Out of State Seminar Expense	(900)	24	5
6	Non-Allowable Out of State Travel Expense	(1,617)	25	6
7	Adjust Provider Tax	(21,182)	42	7
8	Chamber of Commerce Dues	(260)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,651)		49

Summary A

11/30/2025

[illegible]

Summary B

11/30/2025

[illegible]

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		McHenry County	Woodstock	County Gov't.

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	Computer IT Support	\$	McHenry County		\$ 301,624	\$ 301,624	1
2	V	21	Human Resources		McHenry County		69,237	69,237	2
3	V	21	Finance/Administrative Expense		McHenry County		850,449	850,449	3
4	V	21	IT/Virtual Machine Services		McHenry County		108,029	108,029	4
5	V	21	Payroll/Office Supply		McHenry County		1,140	1,140	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			\$			\$ 1,330,479	\$ * 1,330,479	14

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								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								25
26								26
27								27
28								28
29								29
30								30

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

VIII. ALLOCATION OF INDIRECT COSTS

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Computer/IT Support	AllocatedPersonnel	1	1	\$ 301,624	\$	1	\$ 301,624	1
2	21	Human Resources	Allocated Payroll	1	1	69,237	69,237	1	69,237	2
3	21	Finance/Administrative Expense	Allocated Payroll	1	1	850,449	850,449	1	850,449	3
4	21	IT/Virtual Machine Services	Allocated Expense	1	1	108,029		1	108,029	4
5	21	Payroll/Office Supply	Allocated Expense	1	1	1,140		1	1,140	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					\$ 1,330,479	\$ 919,686		\$ 1,330,479	25

Ending: 1/30/2025

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10	Interest Expense		X								110	10
11	Interest Income Offset		X								(110)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	15

\$ N/A

Line # **N/A**

**** 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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2025 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
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
County Operated Facility does not pay Real Estate Tax				14	14
				15	15
				16	16
				17	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Valley Hi Nursing Home COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0046821

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,522 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Valley Hi Nursing Home

0046821

Report Period Beginning:

12/1/2024

Ending:

11/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	124		2006	2006	\$ 13,881,312	\$	40	\$ 347,033	\$ 347,033	\$ 6,641,961	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	15,629		20			15,629	9
10	Various			1989	400,744		20			400,744	10
11	Various			1994	21,235		20			21,235	11
12	Various			1996	695,585		20			695,585	12
13	Various			2006	12,425		20			12,425	13
14	Various			2007	19,483		20	974	974	17,532	14
15	Various			2008	80,862		20	4,043	4,043	40,422	15
16	Various			2009	3,751		20	188	188	3,008	16
17	Various			2010	120,395		20	6,020	6,020	90,300	17
18	Various			2011	92,299		20	4,615	4,615	64,530	18
19	Various			2012	28,004		20	1,400	1,400	31,147	19
20	Various			2013	28,347		14	2,497	2,497	49,095	20
21	Various			2014	63,329		12	4,733	4,733	53,567	21
22	Various			2015	212,593		20	10,756	10,756	115,929	22
23	Various			2016	219,260		10	21,926	21,926	203,716	23
24	Various			2017	9,525		7-13	910	910	7,528	24
25	Various			2018	19,029		5-10	2,781	2,781	19,024	25
26	Various			2019	146,608		2-10	27,304	27,304	177,532	26
27	Various			2020	71,720		5-15	5,313	5,313	31,290	27
28	Various			2021	14,612		5-15	1,361	1,361	6,258	28
29	F/A Disposal -2010			2010	(8,496)					(8,496)	29
30	F/A Disposal -2011				(8,994)					(8,944)	30
31											31
32											32
33											33
34											34
35											35
36	Book Depreciation					667,636					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:

12/1/2024

Ending:

11/30/2025

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	Interior Front Sliding Door Track Roller Assembly	2022	\$ 2,881	\$	5	\$ 576	\$ 576	\$ 2,016	37
38	Front Entrance Landscape Plantings	2022	2,904		5	581	581	2,033	38
39	East Entrance SW & West Courtyard/Landscape Plantings	2022	2,988		5	598	598	2,093	39
40	Irrigation System Repair -SW/West Courtyards	2022	5,720		7	817	817	2,860	40
41	Asphalt Patching, Sealcoat and Striping	2022	19,830		7	2,833	2,833	9,915	41
42	Well Pump Packages Parts and Labor	2022	9,399		5	1,880	1,880	6,907	42
43	New Water Heater and Labor	2022	22,379		15	1,492	1,492	6,341	43
44	7 Cubicle Curtains	2022	2,657		5	531	531	1,682	44
45	Garbage Disposal	2022	2,501		15	167	167	564	45
46	Kitchen Electrical updates	2022	3,282		40	82	82	280	46
47	New Carpet, Paint for Business Office and Reception	2022	42,766		20	2,138	2,138	6,652	47
48	Therapy Room Expansion Project(Electric/flooring/drywall/paint	2022	747,615		40	18,690	18,690	65,415	48
49	Therapy Room Expansion Project Exterior	2022	82,740		20	4,137	4,137	16,548	49
50	Dining Room Circuit Breaker/Electrical/Lighting	2022	38,398		40	960	960	3,600	50
51	Dining Room Window treatments/Steamt table/Chillers	2022	21,329		15	1,422	1,422	5,332	51
52	Pond Liner Replacement Project	2023	686,329		15	45,755	45,755	114,387	52
53	Therapy Room-Framining-drywall-electric, painting, windows	2023	35,370		15	2,358	2,358	7,074	53
54	Shower and Toilet Rooms Floors 2 & 3 - plumbing-electrical	2023	364,507		15	24,300	24,300	60,750	54
55	Painiting, plumbing fixtures								55
56	Field Fastener reapiir - Roofing	2023	3,907		20	195	195	488	56
57	Kitchen Floor Replacement	2023	30,930		20	1,547	1,547	3,223	57
58	New Water Heater and Labor	2024	19,985		10	1,999	1,999	2,166	58
59	Fire System Underground Storage tank Valve Replacement	2024	14,550		20	728	728	789	59
60	Pond Plantings,Steel Edging, Soil Sod and Cobblestones	2024	11,851		5	2,370	2,370	3,555	60
61	HVAC Software Component Upgrades	2024	43,673		15	2,912	2,912	3,155	61
62	Plumbing Backflow Prevention Repair	2024	3,168		5	634	634	951	62
63	Weatherguard Roofing - Roor Repair	2024	19,900		20	995	995	1,493	63
64	Plumbing Well Repair	2024	5,050		15	337	337	505	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 18,385,866	\$ 667,636		\$ 562,887	\$ 562,887	\$ 9,011,791	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:

12/1/2024

Ending:

11/30/2025

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 18,385,866	\$ 667,636		\$ 562,887	\$ (104,749)	\$ 9,011,791	1
2	Variable Frequency Drive for Water Booster Pump	2025	3,715		5	495	495	495	2
3	Main Entrance Sliding Door	2025	3,159		5	158	158	158	3
4	Anti Freeze Loop Upgrade - Fire Protection	2025	15,550		10	648	648	648	4
5	IDPH Tags to correct Fire Alarm System	2025	3,565		5	297	297	297	5
6	Butler Pantry Floor Replacement	2025	13,915		10	1,160	1,160	1,160	6
7	Shingle Roof Repair	2025	4,240		10	106	106	106	7
8	Main Entrance Sliding Door Repair	2025	3,159		5	158	158	158	8
9	Irrigation Repairs	2025	3,776		7	90	90	90	9
10	Memory Care Unit Addition	2025	3,633,897		40	45,424	45,424	45,424	10
11	Irrigation Repairs MCU Land Improvements	2025	8,600		7	615	615	615	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	TOTAL (lines 1 thru 33)		\$ 22,079,442	\$ 667,636		\$ 612,037	\$ (55,599)	\$ 9,060,942	34

**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	\$2,160,661	\$	\$101,400	\$101,400	5-15	\$1,517,714	71
72	Current Year Purchases	559,052		19,220	19,220	5-15	19,220	72
73	Fully Depreciated Assets							73
74	Disposals	(249,355)						74
75	TOTALS	\$2,470,358	\$	\$120,620	\$120,620		\$1,536,934	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Ford E350 Diamond Bus	2019	\$57,919	\$	\$	\$		\$57,919	76
77		2011 Chevy Equinox	2011	20,445					20,445	77
78		Tractor	1985	10,684					10,684	78
79										79
80	TOTALS			\$89,048	\$	\$	\$		\$89,048	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)	\$24,644,848	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$667,636	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$732,657	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$65,021	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$10,686,924	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	CIP	\$5,769	92
93			93
94			94
95		\$5,769	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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: \$ 15,794 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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

Valley Hi Nursing Home
0046821
12/1/2024-11/30/2025

Page 14 Supplemental

Description	Amount
Photo Copier	3,817
Dish Machine	2,400
Water Coolers	259
Garbage Container Lease	4,020
Tables, Tents, Chairs - Picnic Rental	5,298
	<u>15,794</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☒

HOURS PER CNA

3

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,678	\$	\$ 1,678
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	\$	\$ 1,678	\$	\$ 1,678
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,678			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 267,695	\$		\$ 267,695	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			97,184			97,184	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			323,037			323,037	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				237,457		237,457	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39-3				43,720			43,720	12
13	Other (specify): See Attached	39-2					136,062		136,062	13
14	TOTAL			\$		\$ 731,636	\$ 373,519		\$ 1,105,155	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Special Services - Supplies (Line 12-Column 6 - Other) Amount	
Lab-Medicare/Insurance	73,059
X-Rays Medicare Part A & B	12,768
Rental of Medical Equipment	31,490
Medical Services Outpatient Pt. A	12,864
Medication/Oxygen	5,881
Total	136,062

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,964,754	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (525,000))	3,025,437		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	45,001		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	18,174,395		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 23,209,587	\$	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	19,622,983		14
15	Leasehold Improvements, at Historical Cost	2,445,879		15
16	Equipment, at Historical Cost	2,559,406		16
17	Accumulated Depreciation (book methods)	(10,686,924)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	5,769		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,953,113	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 37,162,700	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 219,797	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	562,859		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	373,030		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,155,686	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,835,236		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,835,236	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,990,922	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 33,171,778	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 37,162,700	\$	48

*(See instructions.)

Line #	Other Current Assets:	Amount	Amount
9	Interest Receivable	33,967	
9	DOR- Pensions(GASB 68)	1,797,066	
9	Property Tax Receivable	10,000	
9	Investments	16,172,103	
9	Deferred Outflows -OPEB (gasb75)	161,259	
9			
	Total Line 9	<u>18,174,395</u>	

Line #	Other Non-Current Assets:	Amount	Amount
23	Prepayment on Capital Project	5,679	
	Total Line 23	<u>5,679</u>	

Line #	Other Current Liabilities:	Amount	Amount
36	Bed Tax Liability	54,859	
36	Due to HFS	47,006	
36	Due to General Fund	(344)	
36	Deferred Property Tax Revenue	10,000	
36	Due to Other Cnty. Depts.	122,686	
36	Due to Employee Benefit Fund	131,918	
36	VH Accrued Expense	5,905	
	Total Line 36	<u>372,030</u>	

Line #	Other Non-Current Liabilities:	Amount	Amount
43	OPEB Liability	710,552	
43	Net Pension Liability (GASB 68)	1,721,930	
43	Compensated Absences Payable	244,057	
43	DIR-OPEB (GASB 75)	155,787	
43	DIR - Pensions (GASB68)	2,910	
	Total Line 43	<u>2,835,236</u>	

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 35,697,658	1
2	Restatements (describe):		2
3	Restatement of Beginning FB-Chg. In Accounting Principal	(91,588)	3
4	Reconcile Equit for PPD Audit Adjustments	(19,616)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 35,586,454	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,414,676)	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)	\$ (2,414,676)	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)	\$ 33,171,778	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Valley Hi Nursing Home

0046821

Report Period Beginning: 12/1/2024

Ending: 11/30/2025

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,186,197	1
2	Discounts and Allowances for all Levels	(3,058,542)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,127,655	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	820,090	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 820,090	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	2,589	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	236,410	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	66,037	19
20	Radiology and X-Ray	15,026	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 320,062	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,021,962	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,021,962	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	(163,235)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (163,235)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,126,534	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,551,728	31
32	Health Care	7,211,213	32
33	General Administration	5,802,276	33
	B. Capital Expense		
34	Ownership	683,540	34
	C. Ancillary Expense		
35	Special Cost Centers	1,111,405	35
36	Provider Participation Fee	181,048	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,541,210	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,414,676)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,414,676)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,764,001.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,845,185.00	45
46	MMAI-Medicaid is the Primary Payer	104,278.00	46
47	MMAI-Medicare is the Primary Payer	8,384.00	47
48	Private Pay	2,985,484.00	48
49	Medicare Part A	2,268,796.00	49
50	Other-(specify) Hopsice	1,415,963.00	50
51	Other-(specify) Insurance	735,564.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,127,655	56

Description	Amount
Property Taxes	10,090
DoPNA Recovery	(173,653)
Real Estate Tax District Interest	2
Rebates	326
Total	(163,235)

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	1,896	2,080	\$ 120,381	\$ 57.88	1
2	Assistant Director of Nursing	1,968	2,080	88,431	42.51	2
3	Registered Nurses	38,918	44,423	2,156,263	48.54	3
4	Licensed Practical Nurses	14,178	15,666	682,646	43.58	4
5	CNAs & Orderlies	86,346	96,300	2,483,106	25.79	5
6	CNA Trainees					6
7	Licensed Therapist	1,952	2,080	96,249	46.27	7
8	Rehab/Therapy Aides	3,380	4,405	140,576	31.91	8
9	Activity Director	1,738	1,950	61,629	31.60	9
10	Activity Assistants	8,903	10,114	183,016	18.10	10
11	Social Service Workers	3,765	4,352	127,777	29.36	11
12	Dietician					12
13	Food Service Supervisor	4,077	4,623	126,509	27.37	13
14	Head Cook	9,972	11,237	236,377	21.04	14
15	Cook Helpers/Assistants	4,214	4,988	104,897	21.03	15
16	Dishwashers	16,470	18,163	341,240	18.79	16
17	Maintenance Workers	3,158	3,977	117,836	29.63	17
18	Housekeepers	21,091	23,518	396,658	16.87	18
19	Laundry	7,221	8,312	215,581	25.94	19
20	Administrator	1,936	2,080	157,552	75.75	20
21	Assistant Administrator	1,810	2,080	110,528	53.14	21
22	Other Administrative	12,819	15,072	507,088	33.64	22
23	Office Manager					23
24	Clerical	3,316	3,718	84,371	22.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,476	1,712	42,490	24.82	31
32	Other Health Care(specify)	2,682	3,148	52,735	16.75	32
33	Other(specify)	5,578	6,466	135,576	20.97	33
34	TOTAL (lines 1 - 33)	258,864	292,544	\$ 8,769,512 *	\$ 29.98	34

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	188	\$ 10,406	1-3	35
36	Medical Director	Monthly	47,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	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	16	1,040	11-3	44
45	Social Service Consultant	16	1,040	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	220	\$ 62,386		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,930	\$ 213,287	10-3	50
51	Licensed Practical Nurses	837	47,325	10-3	51
52	Certified Nurse Assistants/Aides	3,021	154,039	10-3	52
53	TOTAL (lines 50 - 52)	6,788	\$ 414,651		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberValley Hi Nursing Home# 0046821Report Period Beginning:12/1/2024Ending:11/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Annarella	Administrator	0	\$ 157,552
Tara Polte	Asst. Administrator	0	110,528
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 268,080

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Anchored Solutions	Scheduling Servicer	15,865
FGMK, LLC	Cost Reporting/Consulting	15,498
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 31,363

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 69,645	
Unemployment Compensation Insurance		
FICA Taxes	648,832	
Employee Health Insurance	1,695,946	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*	496,290	
Pension Expense	989,571	
Employee Physicals	9,037	
Other Employee Benefits	2,371	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 3,911,692

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$ 2,150	
Advertising: Employee Recruitment	17,783	
Health Care Worker Background Check (Indicate # of checks performed 25)	913	
Patient Background Checks	306	
Association Dues (total from pg 22, #4)	11,840	
Dues / Subscriptions	31,703	
Licenses and Permits	300	
Less: Public Relations Expense	()	
PAC and Lobbying payments	(3,366)	
All non-allowable advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 64,384

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	34,747
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 34,747

* Attach copy of IMRF notifications

**See instructions.

FACILITY NAME: Valley Hi Nursing Home
SEMINAR EXPENSE
FYE: 12/1/2024-11/30/2025

DATE	G/ L ACCT#	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
	Admin (6100)						
01/22/25	6100-400600	First National Bank of Omaha	CMS 2025 Surveyor Guidance Webinar Series	Thomas Annarella	Administrator	Woodstock, IL	420.00
04/03/25	6100-400600	First National Bank of Omaha	Social Service Training Day	Maria Viray	Social Service Worker	Woodstock, IL	165.60
05/08/25	6100-400600	Arlington Medical Supply	Basic Life Support CPR	Admin Staff	Administration	Woodstock, IL	42.77
05/29/25	6100-400600	Arlington Medical Supply	Basic Life Support CPR	Admin Staff	Administration	Woodstock, IL	46.25
06/03/25	6100-400600	Arlington Medical Supply	Basic Life Support CPR	Admin Staff	Administration	Woodstock, IL	96.66
08/01/25	6100-400600	Durham Group	Executive Coaching and Team Development	Thomas Annarella & Tara Polte	(Asst) Administrator	Woodstock, IL	4,253.65
08/15/25	6100-400600	First National Bank of Omaha	Ethics in Social Services in LTC and Dementia	Maria Viray	Social Service Worker	Woodstock, IL	87.98
08/15/25	6100-400600	First National Bank of Omaha	Ethics in Social Services in LTC and Dementia	Allison Mann	Social Service Worker	Woodstock, IL	87.98
08/19/25	6100-400600	Arlington Medical Supply	Basic Life Support CPR	Admin Staff	Administration	Woodstock, IL	101.42
09/02/25	6100-400600	First National Bank of Omaha	Survey Prep and Understanding Webinar	Thomas Annarella, Tara Polte, Allison Mann	Administration	Woodstock, IL	212.25
09/09/25	6100-400600	First National Bank of Omaha	IHCA Convention and Expo	Thomas Annarella	Administrator	Peoria, IL	198.75
10/16/25	6100-400600	First National Bank of Omaha	Care Area Assessment Review	Admin Staff	Administration	Woodstock, IL	195.00
10/19/25	6100-400600	First National Bank of Omaha	AHCA/NCAL Convention and Expo	Thomas Annarella	Administrator	Las Vegas, NV	900.00
10/23/25	6100-400600	First National Bank of Omaha	Strategies for Workforce Retention Webinar	Thomas Annarella	Administrator	Woodstock, IL	349.00
10/27/25	6100-400600	First National Bank of Omaha	AI Literacy Essentials for Aging Services Webinar	Thomas Annarella	Administrator	Woodstock, IL	218.00
	Housekeeping (6130)						
05/29/25	6130-400600	Arlington Medical Supply	Basic Life Support CPR	Housekeeping Staff	Housekeeping	Woodstock, IL	92.50
08/01/25	6130-400600	Durham Group	Executive Coaching and Team Development	Jennifer Boege	Hskpg Supervisor	Woodstock, IL	1,248.80
09/02/25	6130-400600	First National Bank of Omaha	Survey Prep and Understanding Webinar	Jennifer Boege	Hskpg Supervisor	Woodstock, IL	70.75
09/09/25	6130-400600	First National Bank of Omaha	IHCA Convention and Expo	Jennifer Boege	Hskpg Supervisor	Peoria, IL	198.75
	Dietary (6140)						
05/08/25	6140-400600	Arlington Medical Supply	Basic Life Support CPR	Dietary Staff	Dietary	Woodstock, IL	42.77
05/23/25	6140-400600	Arlington Medical Supply	Basic Life Support CPR	Dietary Staff	Dietary	Woodstock, IL	56.66
05/28/25	6140-400600	Kendrick Nez	Sanitation Course Reimbursement	Kendrick Nez	Dietary	Woodstock, IL	179.00
08/01/25	6140-400600	Durham Group	Executive Coaching and Team Development	Michael Azzano	Dietary Manager	Woodstock, IL	2,497.55
09/02/25	6140-400600	First National Bank of Omaha	Survey Prep and Understanding Webinar	Michael Azzano & Kendrick Nez	Dietary	Woodstock, IL	141.50
09/09/25	6140-400600	First National Bank of Omaha	IHCA Convention and Expo	Michael Azzano	Dietary Manager	Peoria, IL	198.75
	Nursing (6150)						
04/09/25	6150-400600	First National Bank of Omaha	Certified Alzheimer's Disease and Dementia Care Training	Nick Partridge	Memory Care Director	Woodstock, IL	3,350.00
05/08/25	6150-400600	Arlington Medical Supply	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	256.69
05/23/25	6150-400600	Arlington Medical Supply	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	283.34
05/29/25	6150-400600	Arlington Medical Supply	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	92.50
06/03/25	6150-400600	Arlington Medical Supply	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	483.34
06/03/25	6150-400600	First National Bank of Omaha	Certified Dementia Practitioner Group Initial Application	Nursing Staff	Nursing	Woodstock, IL	1,170.00
07/28/25	6150-400600	Professional Nursing Services	IV Therapy Class for 9 Nurses	Nursing Staff	Nursing	Plainfield, IL	3,600.00
08/15/25	6150-400600	First National Bank of Omaha	Skin and Wound Management	Jennifer Peter	Nursing	Oakbrook Terrace, IL	2,297.00
09/09/25	6150-400600	First National Bank of Omaha	IHCA Convention and Expo	Brittany Tollberg	DON	Peoria, IL	198.75
08/01/25	6150-400600	Durham Group	Executive Coaching and Team Development	Brittany Tollberg & Angela Lawrence	DON & ADON	Woodstock, IL	8,000.00
08/19/25	6150-400600	Arlington Medical Supply	Basic Life Support CPR	Nursing Staff	Nursing	Woodstock, IL	202.87
08/21/25	6150-400600	Jennifer Peter	Wound Care Training Exam Fee	Jennifer Peter	Nursing	Oakbrook Terrace, IL	380.00
09/02/25	6150-400600	First National Bank of Omaha	Survey Prep and Understanding Webinar	Brittany Tollberg, Angela Lawrence, Marrissa Hansen, Beth Partridge, and Cari Ison	Nursing	Woodstock, IL	353.75
	Therapy (6160)						
	6160-400600						
	Activities (6170)						
05/08/25	6170-400600	Arlington Medical Supply	Basic Life Support CPR	Activities Staff	Activities	Woodstock, IL	42.77
05/29/25	6170-400600	Arlington Medical Supply	Basic Life Support CPR	Activities Staff	Activities	Woodstock, IL	138.75
08/19/25	6170-400600	Arlington Medical Supply	Basic Life Support CPR	Activities Staff	Activities	Woodstock, IL	50.71
09/02/25	6170-400600	First National Bank of Omaha	Survey Prep and Understanding Webinar	Gwen Lagerhausen	Activities Supervisor	Woodstock, IL	70.75
	Indirect (6190)						
06/01/25	6190-400600	VGM Group	CE Solutions Online Training	VH Staff	VH Staff	Woodstock, IL	2,573.75
							35,647.31
ADI Out of State							-900
Total							34,747.31

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>7,334</u> |
| <u>Other, please specify Collaborative Healthcare Urgency Group</u> | <u>1,140</u> |
| | <u>8,474</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>3,366</u> |
| <u>Other, please specify Collaborative Healthcare Urgency Group</u> | |
| | <u>3,366</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>10,700</u> |
| <u>Other, please specify Collaborative Healthcare Urgency Group</u> | <u>1,140</u> |
| | <u>11,840</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 67,680 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 159,866
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,589
- (12) 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? Yes
- 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
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Baker Tilley
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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.