

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 01/01/04 Ending: 12/31/04

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 _____

	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	105	Skilled (SNF)	105	38,430	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	105	TOTALS	105	38,430	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	511	916	3,061	4,488	8
9	SNF/PED					9
10	ICF	11,781	21,134		32,915	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,292	22,050	3,061	37,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.33%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 30-Jun-88

J. Was the facility purchased or leased after January 1, 1978?
YES Date 30-Jun-88 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 105 and days of care provided 3,061

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 31-Dec-04 Fiscal Year: 12/31/04
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/04 Ending: 12/31/04

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	268,162		24,685	292,847		292,847		292,847		1
2	Food Purchase		203,696		203,696	127	203,823	(41,060)	162,763		2
3	Housekeeping	164,316	18,770	714	183,800		183,800	(1,917)	181,883		3
4	Laundry	75,737	13,151		88,888		88,888		88,888		4
5	Heat and Other Utilities			127,569	127,569		127,569	(20,648)	106,921		5
6	Maintenance	106,215	21,915	25,643	153,773		153,773	(655)	153,118		6
7	Other (specify):*										7
8	TOTAL General Services	614,430	257,532	178,611	1,050,573	127	1,050,700	(64,280)	986,420		8
	B. Health Care and Programs										
9	Medical Director			200	200		200		200		9
10	Nursing and Medical Records	2,399,918	62,385	154,623	2,616,926		2,616,926	(13,436)	2,603,490		10
10a	Therapy	9,789	2,023	148,163	159,975		159,975		159,975		10a
11	Activities	112,980	5,290	370	118,640		118,640		118,640		11
12	Social Services	81,198	660	1,299	83,157		83,157	(3,976)	79,181		12
13	Nurse Aide Training	23,529	927	2,250	26,706		26,706		26,706		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,627,414	71,285	306,905	3,005,604		3,005,604	(17,412)	2,988,192		16
	C. General Administration										
17	Administrative	68,962			68,962		68,962		68,962		17
18	Directors Fees										18
19	Professional Services			39,953	39,953		39,953		39,953		19
20	Dues, Fees, Subscriptions & Promotions			36,488	36,488	668	37,156	(2,201)	34,955		20
21	Clerical & General Office Expenses	200,542	17,914	38,567	257,023	281	257,304	(118,480)	138,824		21
22	Employee Benefits & Payroll Taxes			843,991	843,991	(633)	843,358		843,358		22
23	Inservice Training & Education			1,064	1,064		1,064		1,064		23
24	Travel and Seminar			6,574	6,574	(443)	6,131		6,131		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			83,126	83,126		83,126		83,126		26
27	Other (specify):*										27
28	TOTAL General Administration	269,504	17,914	1,049,763	1,337,181	(127)	1,337,054	(120,681)	1,216,373		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,511,348	346,731	1,535,279	5,393,358		5,393,358	(202,372)	5,190,986		29

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

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

Facility Name & ID Number Snyder Village Health Center

#0033647

Report Period Beginning:

01/01/04

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			193,433	193,433		193,433	1,742	195,175			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,992	98,992		98,992	(27,593)	71,399			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,585	9,585		9,585		9,585			35
36	Other (specify):*											36
37	TOTAL Ownership			302,010	302,010		302,010	(25,851)	276,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,524	11,209	187,733		187,733	(770)	186,963			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,646	57,646		57,646		57,646			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		176,524	68,855	245,379		245,379	(770)	244,609			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,511,348	523,255	1,906,144	5,940,747		5,940,747	(228,993)	5,711,754			45

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

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Report Period Beginning:

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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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,986)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,742	30.3		9
10	Interest and Other Investment Income	(27,593)	32.3		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				24
25	Fund Raising, Advertising and Promotional		43.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,201)	20.3		28
29	Other-Attach Schedule	(181,955)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (228,993)		\$	30

OHF 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	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))	\$ (228,993)		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.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Amount			\$	\$ *
1	V		\$				\$	\$	1
2	V								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		\$				\$	\$ *	14

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

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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									\$	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.

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	Commerce Bank		X	Building	12,758	Aug-87	\$ 3,450,000	\$ 1,386,428	Sep-26	0.0507	\$ 73,601	1						
2	CDAP Village Metamora		X	Building	4,340	Various	614,000	198,061	Various	0.0375	8,034	2						
3	Commerce Bank		X	Bldg Construction	4,855	Feb-01	500,000	184,723	May-07	0.0425	9,254	3						
4	Commerce Bank		X	Patient Transport Vehicle	562	Nov-02	29,900	17,517	Oct-07	0.0425	888	4						
5	Woodford County		X	Bldg Construction	1,887	Dec-00	100,000	20,249	Nov-05	0.0500	1,587	5						
	Working Capital																	
6	Gift Annuity		X	Building	510	Various	84,000	65,969	Various	0.0675	5,628	6						
7					-							7						
8					-				Less: Interest Income		(27,593)	8						
9	TOTAL Facility Related				\$24,912.00		\$ 4,777,900	\$ 1,872,948			\$ 71,399	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,777,900	\$ 1,872,948			\$ 71,399	15						

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

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyder Village Health Center COUNTY Woodford
 FACILITY IDPH LICENSE NUMBER 0033647
 CONTACT PERSON REGARDING THIS REPORT Keith Swartzentruber
 TELEPHONE (309) 367-4300 FAX #: (309) 367-2235

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
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 & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION

A. Square Feet: 36,870 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories One

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

Snyder Village Retirement Community Apartments - 41 Apartments @ 38,793 Ft.

Snyder Village Retirement Community Cottages - 118 Cottages @ 283,200 Ft.

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>155,422</u>	<u>1987</u>	<u>\$ 43,000</u>	1
2	<u>Nursing Home</u>		<u>2001</u>	<u>1,300</u>	2
3	TOTALS	<u>155,422</u>		<u>\$ 44,300</u>	3

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	61		Jan-88	Jan-88	\$ 1,929,231	\$ 42,872	45	\$ 42,872	\$	\$ 707,386	4
5			Jan-92	Jan-92	127,495	2,833	45	2,833		35,651	5
6			Jan-92	Jan-92	33,830	1,353	25	1,353		16,463	6
7	18		Jan-94	Jan-94	600,872	13,353	45	13,353		144,655	7
8	26		Jan-94	Jan-94	1,256,597	27,924	45	27,924		281,570	8
		Improvement Type**									
9		Fire Control System		Oct-89	5,152	258	20	258		3,930	9
10		Century Tub		Oct-89	7,694		10			7,694	10
11		Asphalt		Jul-90	1,820	91	20	91		1,320	11
12		Alzheimer's Courtyard		Aug-90	3,644		10			3,644	12
13		Heat Exchanger		Mar-90	1,650		10			1,650	13
14		Tub		May-91	1,465		10			1,465	14
15		Door Locks		Dec-91	1,400	70	20	70		916	15
16		Door Locks		Apr-92	1,200	60	20	60		765	16
17		Patio		Jun-92	1,219		10			1,219	17
18		Entrance Light		Jun-93	619		10			619	18
19		Land Improvement		Dec-94	25,546	1,277	20	1,277		12,878	19
20		Services Windows		Mar-95	201,662	4,481	45	4,481		42,069	20
21		Landscaping		Jan-95	13,848	692	20	692		4,748	21
22		Canopy		Dec-95	1,102	55	20	55		500	22
23		Electrical Maintenance		Sep-95	595	40	15	40		371	23
24		Door Locks		Aug-95	505	34	15	34		318	24
25		Front Canopy		Sep-96	44,945	999	45	999		7,475	25
26		Tower		May-96	7,360	368	20	368		3,189	26
27		Door Open		Sep-96	3,344	334	10	334		2,785	27
28		Landscaping		Jul-97	1,500	75	20	75		563	28
29		Front Door Wiring		Mar-97	1,396	70	20	70		547	29
30		Kelly Glass		Jan-98	3,527	176	20	176		1,233	30
31		MTCO Phone System		Aug-98	18,914	757	25	757		3,793	31
32		Carpet		Nov-98	15,719	1,572	10	1,572		9,694	32
33		Heater		Apr-99	1,784	178	10	178		1,024	33
34		Security Camera		Jan-99	2,510	167	15	167		1,003	34
35		Motion Detector		Jan-99	790		10	79	79	474	35
36		Shelving		Jan-99	673		10	67	67	402	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 Snyder Village Health Center

0033647

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Automatic Door Open	Dec-00	\$ 5,449	\$	15	\$ 363	\$ 363	\$ 1,634	37
38	Blacktop	Dec-00	21,736	1,087	20	1,087		4,438	38
39	Sunroom	May-00	86,410	1,920	45	1,920		8,637	39
40	Generator	Feb-00	36,206	1,810	20	1,810		8,071	40
41	Time Clock	Mar-00	7,789	1,558	5	1,558		7,530	41
42	Motion Detector	May-00	5,714	571	10	571		2,665	42
43	Nursing Office Addition	Apr-01	751,810	16,707	45	16,707		58,565	43
44	Sunroom	Jan-01	11,315	1,132	10	1,132		4,528	44
45	Tower	Jun-01	5,640	564	10	564		2,021	45
46	Door	Nov-01	2,545	255	10	255		807	46
47	Carpet	Nov-01	3,529	353	10	353		1,118	47
48	Landscaping	Apr-01	4,943	247	20	247		926	48
49	Blacktop	Nov-01	12,054	603	20	603		1,910	49
50	Roof	Jun-02	36,779	2,452	15	1,431	(1,021)	4,293	50
51	Hall 2 Room Alert	Feb-02	5,015	1,003	5	915	(88)	2,745	51
52	Door, Tile, Drapes, Wall	Mar-03	4,557	570	8	(475)	(1,045)		52
53	Door	Feb-04	1,640	501	3		(501)		53
54	Roam Alert	Apr-04	4,488	673	5		(673)		54
55	Carpet Hall 2	Aug-04	856	72	5		(72)		55
56	Draperly	Apr-04	2,335	350	5		(350)		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)		\$ 5,330,418	\$ 132,517		\$ 129,276	\$ (3,241)	\$ 1,411,901	70

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 253,347	\$ 41,509	\$ 41,509	\$	various	\$ 178,978	71
72	Current Year Purchases	14,556	3,086	3,086		various	3,086	72
73	Fully Depreciated Assets	538,501				various	538,501	73
74								74
75	TOTALS	\$ 806,404	\$ 44,595	\$ 44,595	\$		\$ 720,565	75

D. Vehicle Depreciation (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	Resident Care	1985 Ford Van	Jan-91	\$ 3,130	\$	\$	\$	3	\$ 3,130	76
77	Resident Transportation	1994 Van	Jan-94	47,025	3,527	3,526	(1)	10	47,025	77
78	Resident Transportation	1996 Van	Jan-96	51,573	5,157	5,157		10	41,687	78
79	Resident Care	1992 Truck	Jan-97	16,367				10	16,367	79
80	TOTALS			\$ 170,254	\$ 16,321	\$ 21,304	\$ 4,983		\$ 153,706	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)	\$ 6,351,376	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,433	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 195,175	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,742	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,286,172	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (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	Maintenance Use	1999 Tate Truck	Jan-99	\$ 6,850	\$ 343	\$ 343	\$	5	\$ 6,850	76
77	Maintenance Use	1999 Grimm Truck	Jan-99	15,409	2,311	2,311		5	15,409	77
78	Patient Transport	2000 Ford Van	Sep-02	29,900	4,983	9,967	4,984	3	23,238	78
79										79
80	TOTALS			\$ 52,159	\$ 7,637	\$ 12,621	\$ 4,984		\$ 45,497	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)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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: \$ 9,585

Description: Postage Meter \$1,050 and Copier \$8,535

(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

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. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* 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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		927		927
3	Classroom Wages (a)		10,311		10,311
4	Clinical Wages (b)		5,155		5,155
5	In-House Trainer Wages (c)		8,063		8,063
6	Transportation				
7	Contractual Payments		1,000		1,000
8	Nurse Aide Competency Tests		1,250		1,250
9	TOTALS	\$	\$ 26,706	\$	\$ 26,706
10	SUM OF line 9, col. 1 and 2 (e)	\$	26,706		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	16

- (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 aide 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 aides

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	174	\$ 9,486	\$	174	\$ 9,486	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		128	6,553		128	6,553	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		321	18,297	1,865	321	20,162	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescripts				92,372		92,372	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): Medical Supplies	39.2					83,382		83,382	13
14	TOTAL			\$	623	\$ 34,337	\$ 177,620	623	\$ 211,957	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 nurse aides, who help with the above activities should not be listed on this schedule.

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	\$ 439,928	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (28,500))	616,276		3
4	Supply Inventory (priced at FIFO)	29,831		4
5	Short-Term Investments	262,657		5
6	Prepaid Insurance	34,244		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,354,436	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,300		13
14	Buildings, at Historical Cost	5,155,936		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	1,026,593		16
17	Accumulated Depreciation (book methods)	(2,166,101)		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 (spc Resident in Need / Endowment	253,077		22
23	Other(specify): Construction in Progress			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,313,805	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,668,241	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ (83,053)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(130,172)		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	Employee Benefits Payable	(137,645)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (350,870)	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	(1,872,948)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (1,872,948)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,223,818)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,444,423)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (5,668,241)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,468,649	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,468,649	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(24,225)	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) Rounding	(1)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (24,226)	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)	\$ 3,444,423	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/04

Ending:

12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All require

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.

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,731,244	1
2	Discounts and Allowances for all Levels	(959,944)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,771,300	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	350,159	6
7	Oxygen	49,341	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 399,500	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,195	11
12	Gift and Coffee Shop	10,897	12
13	Barber and Beauty Care	3,946	13
14	Non-Patient Meals	18,986	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	215,951	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	16,868	20
21	Other Medical Services	162,899	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 437,742	23
D. Non-Operating Revenue			
24	Contributions	141,142	24
25	Interest and Other Investment Income***	27,593	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 168,735	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	117,168	28
28a	Other Income	22,077	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 139,245	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,916,522	30

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,050,573	31
32	Health Care	3,005,604	32
33	General Administration	1,337,181	33
B. Capital Expense			
34	Ownership	302,010	34
C. Ancillary Expense			
35	Special Cost Centers	187,733	35
36	Provider Participation Fee	57,646	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,940,747	40
41	Income before Income Taxes (line 30 minus line 40)**	(24,225)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (24,225)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Snyder Village Health Center

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Report Period Beginning:

01/01/04

Ending:

12/31/04

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	1,602	1,829	\$ 44,648	\$ 24.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,297	33,891	709,781	20.94	3
4	Licensed Practical Nurses	13,991	15,008	274,592	18.30	4
5	Nurse Aides & Orderlies	105,938	114,501	1,321,293	11.54	5
6	Nurse Aide Trainees	2,296	2,296	23,529	10.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	770	846	9,789	11.57	8
9	Activity Director	1,889	2,061	23,478	11.39	9
10	Activity Assistants	9,073	9,882	89,502	9.06	10
11	Social Service Workers	6,329	6,913	81,198	11.75	11
12	Dietician					12
13	Food Service Supervisor	2,058	2,359	32,220	13.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,089	28,800	235,942	8.19	15
16	Dishwashers					16
17	Maintenance Workers	7,882	8,367	106,215	12.69	17
18	Housekeepers	17,058	18,051	164,316	9.10	18
19	Laundry	8,515	9,113	75,737	8.31	19
20	Administrator	1,984	2,160	68,962	31.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,974	2,185	34,366	15.73	23
24	Clerical	11,419	12,545	138,467	11.04	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	4,656	5,258	49,604	9.43	33
34	TOTAL (lines 1 - 33)	254,820	276,065	\$ 3,483,639 *	\$ 12.62	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	207	\$ 7,750	1.3	35
36	Medical Director	2	200	9.3	36
37	Medical Records Consultant	8	200	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	10.3	39
40	Physical Therapy Consultant	162	8,939	10a.3	40
41	Occupational Therapy Consultant	57	2,986	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	370	11.3	44
45	Social Service Consultant	26	1,299	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	481	\$ 22,644		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	410	\$ 14,848	10.3	50
51	Licensed Practical Nurses	1,640	54,319	10.3	51
52	Nurse Aides	4,619	83,700	10.3	52
53	TOTAL (lines 50 - 52)	6,669	\$ 152,867		53

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1		\$		\$		\$		\$		\$		\$
2	Carpentry	May 2001	1,244		124	249	249	249	249	124		
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 1,244		\$ 124	\$ 249	\$ 249	\$ 249	\$ 249	\$ 124	\$	\$

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning: 01/01/04

Ending: 12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 5,200
- (3) Did the nursing home make political contributions or payments to a political organization? No 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? _____
- (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? 4.8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,322 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. No
- (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 _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,646
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 of Public Aid, 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? Yes. OP Therapy 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 benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 18,986
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold Banwart LTD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.