

		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

<p>I. IDPH Facility ID Number: <u>0033647</u></p> <p>Facility Name: <u>Snyder Village</u></p> <p>Address: <u>1200 East Partridge</u> <u>Metamora</u> <u>61548</u> <small>Number City Zip Code</small></p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 367-4300</u> Fax # <u>(309) 367-2235</u></p> <p>IDPA ID Number: <u>37-1194111001</u></p> <p>Date of Initial License for Current Owners: <u>6/30/1988</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501 (c) 3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other <u> </u></td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Keith Swartzentruber</u> Telephone Number: <u>(309) 367-4300</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Keith Swartzentruber</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Executive Director</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) _____ Fax # _____</td> </tr> </table> <p align="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Keith Swartzentruber</u>		(Title) <u>Executive Director</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) _____ Fax # _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) _____ Fax # _____																																						

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 01-Jan-05 Ending: 31-Dec-05

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	38,325	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	38,325	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	400	1,036	3,587	5,023	8
9	SNF/PED					9
10	ICF	10,604	20,078		30,682	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,004	21,114	3,587	35,705	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.16%

D. How many bed-hold days during this year were paid by the Department? _____ (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 3,587

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-05 Fiscal Year: 31-Dec-05

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

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01-Jan-05 Ending: 31-Dec-05

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	285,059		25,416	310,475		310,475		310,475		1
2	Food Purchase		216,280		216,280		216,280	(40,777)	175,503		2
3	Housekeeping	167,780	21,460	989	190,229		190,229	(900)	189,329		3
4	Laundry	72,572	13,053		85,625		85,625		85,625		4
5	Heat and Other Utilities			136,756	136,756		136,756	(30,109)	106,647		5
6	Maintenance	109,927	19,712	21,488	151,127		151,127	(918)	150,209		6
7	Other (specify):*										7
8	TOTAL General Services	635,338	270,505	184,649	1,090,492		1,090,492	(72,704)	1,017,788		8
	B. Health Care and Programs										
9	Medical Director			400	400		400		400		9
10	Nursing and Medical Records	2,474,681	64,561	14,329	2,553,571		2,553,571	(14,304)	2,539,267		10
10a	Therapy	10,145	2,640	187,284	200,069		200,069		200,069		10a
11	Activities	115,222	5,688	807	121,717		121,717		121,717		11
12	Social Services	80,215	1,086	1,460	82,761		82,761	(4,222)	78,539		12
13	CNA Training	3,217		635	3,852		3,852		3,852		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,683,480	73,975	204,915	2,962,370		2,962,370	(18,526)	2,943,844		16
	C. General Administration										
17	Administrative	100,415			100,415		100,415		100,415		17
18	Directors Fees										18
19	Professional Services			31,966	31,966		31,966		31,966		19
20	Dues, Fees, Subscriptions & Promotions			46,169	46,169	(631)	45,538	(15,451)	30,087		20
21	Clerical & General Office Expenses	200,925	20,011	43,009	263,945	(1,759)	262,186	(235,111)	27,075		21
22	Employee Benefits & Payroll Taxes			923,779	923,779		923,779		923,779		22
23	Inservice Training & Education			1,891	1,891		1,891		1,891		23
24	Travel and Seminar			9,005	9,005	2,390	11,395		11,395		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			83,982	83,982		83,982		83,982		26
27	Other (specify):*										27
28	TOTAL General Administration	301,340	20,011	1,139,801	1,461,152		1,461,152	(250,562)	1,210,590		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,620,158	364,491	1,529,365	5,514,014		5,514,014	(341,792)	5,172,222		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-Jan-05 Ending: 31-Dec-05

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			176,048	176,048		176,048	(1,514)	174,534			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,007	91,007		91,007	(13,406)	77,601			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,579	9,579		9,579		9,579			35
36	Other (specify):*											36
37	TOTAL Ownership			276,634	276,634		276,634	(14,920)	261,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,388	17,216	194,604		194,604		194,604			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		177,388	74,704	252,092		252,092		252,092			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,620,158	541,879	1,880,703	6,042,740		6,042,740	(356,712)	5,686,028			45

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01-Jan-05 Ending: 31-Dec-05

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	(18,751)	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	(1,514)	30.3		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				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	(15,567)	43.3		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising	(327)	20.3		28
29 Other-Attach Schedule	(320,552)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (356,712)		\$	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))	\$ (356,712)		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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$ -			\$ -		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.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01-Jan-05 Ending: 31-Dec-05

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.

Table with 11 columns: 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 (Hours, Percent), 7 Compensation Included in Costs for this Reporting Period** (Description, Amount), 8 Schedule V. Line & Column Reference. Rows 1-12 are empty, row 13 is shaded and labeled 'TOTAL'.

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 01-Jan-05

Ending: 31-Dec-05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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-Jan-05 Ending: 31-Dec-05

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	Commerce Bank		X	Building	\$12,758.00	Aug-87	\$ 3,450,000	\$ 1,272,149	Sep-26	0.0507	\$ 67,662	1
2	CDAP Village Metamora		X	Building	\$4,340.00	Various	614,000	169,638	Various	0.0375	7,087	2
3	Commerce Bank		X	Bldg Construction	\$4,855.00	Feb-01	500,000	136,563	May-07	0.0425	10,100	3
4	Commerce Bank		X	Patient Transport Vehicle	\$562.00	Nov-02	29,900	11,667	Oct-07	0.0425	895	4
5	Woodford County		X	Bldg Construction	\$1,887.00	Dec-00	100,000		Nov-05	0.0500	510	5
Working Capital												
6	Gift Annuity		X	Building	\$510.00	Various	84,000	61,907	Various	0.0675	4,753	6
7												7
8									Less: Interest Income		(13,406)	8
9	TOTAL Facility Related				\$24,912.00		\$ 4,777,900	\$ 1,651,923			\$ 77,601	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	\$ 1,651,923			\$ 77,601	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01-Jan-05

Ending:

31-Dec-05

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 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 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000 _____	8	
	2001 _____	9	
	2002 _____	10	
	2003 _____	11	
	2004 _____	12	
			FOR OHF USE ONLY
		13 FROM R. E. TAX STATEMENT FOR 2004 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01-Jan-05 Ending:

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 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).

Snyder Village Retirement Community Apartments - 41 Apartments @ 38,793 Ft²

Snyder Village Retirement Community Cottages - 118 Cottages @ 283,200 Ft²

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>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	155,422		\$ 44,300	3

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01-Jan-05

Ending:

31-Dec-05

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	\$	\$ 750,258	4
5			Jan-92	Jan-92	127,495	2,833	45	2,833		38,484	5
6			Jan-92	Jan-92	33,830	1,353	25	1,353		17,816	6
7	18		Jan-94	Jan-94	600,872	13,353	45	13,353		158,008	7
8	26		Jan-94	Jan-94	1,256,597	27,924	45	27,924		309,494	8
	Improvement Type**										
9		Fire Control System		Oct-89	5,152	258	20	258		4,188	9
10		Century Tub		Oct-89	7,694		10			7,694	10
11		Asphalt		Jul-90	1,820	91	20	91		1,411	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		986	15
16		Door Locks		Apr-92	1,200	60	20	60		825	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		14,155	19
20		Services Windows		Mar-95	201,662	4,481	45	4,481		46,550	20
21		Landscaping		Jan-95	13,848	692	20	692		5,440	21
22		Canopy		Dec-95	1,102	55	20	55		555	22
23		Electrical Maintenance		Sep-95	595	40	15	40		411	23
24		Door Locks		Aug-95	505	34	15	34		352	24
25		Front Canopy		Sep-96	44,945	999	45	999		8,474	25
26		Tower		May-96	7,360	368	20	368		3,557	26
27		Door Open		Sep-96	3,344	334	10	334		3,119	27
28		Landscaping		Jul-97	1,500	75	20	75		638	28
29		Front Door Wiring		Mar-97	1,396	70	20	70		617	29
30		Kelly Glass		Jan-98	3,527	176	20	176		1,409	30
31		MTCO Phone System		Aug-98	18,914	757	25	757		4,550	31
32		Carpet		Nov-98	15,719	1,572	10	1,572		11,266	32
33		Heater		Apr-99	1,784	178	10	178		1,202	33
34		Security Camera		Jan-99	2,510	167	15	167		1,170	34
35		Motion Detector		Jan-99	790		10	79	79	553	35
36		Shelving		Jan-99	673		10	67	67	469	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

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01-Jan-05

Ending:

31-Dec-05

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	\$ 1,997	37
38	Blacktop	Dec-00	21,736	1,087	20	1,087		5,525	38
39	Sunroom	May-00	86,410	1,920	45	1,920		10,557	39
40	Generator	Feb-00	36,206	1,810	20	1,810		9,881	40
41	Time Clock	Mar-00	7,789	260	5	259	(1)	7,789	41
42	Motion Detector	May-00	5,714	571	10	571		3,236	42
43	Nursing Office Addition	Apr-01	751,810	16,707	45	16,707		75,272	43
44	Sunroom	Jan-01	11,315	1,132	10	1,132		5,660	44
45	Tower	Jun-01	5,640	564	10	564		2,585	45
46	Door	Nov-01	2,545	255	10	255		1,062	46
47	Carpet	Nov-01	3,529	353	10	353		1,471	47
48	Landscaping	Apr-01	4,943	247	20	247		1,173	48
49	Blacktop	Nov-01	12,054	603	20	603		2,513	49
50	Roof	Jun-02	36,779	2,452	15	2,452		8,787	50
51	Hall 2 Room Alert	Feb-02	5,015	1,003	5	1,003		3,924	51
52	Door, Tile, Drapes, Wall	Mar-03	4,557	570	8	570		1,616	52
53	Door	Feb-04	1,640	547	3	547		1,047	53
54	Roam Alert	Apr-04	4,488	898	5	898		1,572	54
55	Carpet Hall 2	Aug-04	856	171	5	171		242	55
56	Draperly	Apr-04	2,335	467	5	467		818	56
57	Heat Pump	Apr-05	2,165	189	10	163	(26)	163	57
58	Water Heater	Jun-05	4,240	247	10	247		247	58
59	Therapy room door	Oct-05	755	38	5	38		38	59
60	Hall 1 Nurses Station	Oct-05	9,010	113	20	112	(1)	112	60
61	Service Door	Nov-05	950	53	3	52	(1)	52	61
62	Blacktop Sealcoat	Oct-05	3,373	169	5	168	(1)	168	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,350,911	\$ 132,515		\$ 132,994	\$ 479	\$ 1,549,755	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-Jan-05 Ending: 31-Dec-05

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	\$ 203,559	\$ 27,284	\$ 27,284	\$	various	\$ 145,004	71
72	Current Year Purchases	70,367	6,109	6,109		various	6,109	72
73	Fully Depreciated Assets	602,845				various	602,845	73
74								74
75	TOTALS	\$ 876,771	\$ 33,393	\$ 33,393	\$		\$ 753,958	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	99 Tate & Grimm Truck	Jan-99	\$ 22,259	\$	\$	\$	5	\$ 22,259	76
77	Resident Transportation	1994 Van	Jan-94	47,025				10	47,025	77
78	Resident Transportation	1996 Van	Jan-96	51,573	5,157	5,157		10	46,844	78
79	Patient Transport	2000 Ford Van	Sep-02	29,900	4,983	2,990	(1,993)	10	26,228	79
80	TOTALS			\$ 150,757	\$ 10,140	\$ 8,147	\$ (1,993)		\$ 142,356	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)	\$ 6,422,739	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 176,048	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,534	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,514)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,446,069	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	\$ 6,921	92
93			93
94			94
95		\$ 6,921	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

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. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

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: \$ 9,579 Description: Postage Meter \$1,056 and Copier \$8,523

(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.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01-Jan-05 Ending: 31-Dec-05
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION: _____ IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA <u>80</u>	3. CLINICAL PORTION: _____ IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA <u>40</u>
---	--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		3,217		3,217
6	Transportation				
7	Contractual Payments		235		235
8	CNA Competency Tests		400		400
9	TOTALS	\$	\$ 3,852	\$	\$ 3,852
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,852		

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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

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

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

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

	Service	Schedule V Line & Column Reference	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	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	221	\$ 14,969	\$ 627	221	\$ 15,596	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		234	17,384	50	234	17,434	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		416	27,966	1,962	416	29,928	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 prescrpts				96,394		96,394	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					80,994		80,994	13
14	TOTAL			\$	871	\$ 60,319	\$ 180,027	871	\$ 240,346	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.

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	\$ 203,812	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (15,000))	976,994		3
4	Supply Inventory (priced at FIFO)	32,189		4
5	Short-Term Investments	252,865		5
6	Prepaid Insurance	19,441		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)	\$ 1,485,301	\$	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	5,159,309		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,113,080		16
17	Accumulated Depreciation (book methods)	(2,342,148)		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 (spcResident in Need / Endowment)	363,989		22
23	Other(specify): Construction in Progress	6,921		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,345,451	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,830,752	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ (85,645)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(155,639)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(72)		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	(148,029)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (389,385)	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	(1,651,923)		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)	\$ (1,651,923)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,041,308)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,789,444)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (5,830,752)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,444,423	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,444,423	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	345,021	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)	\$ 345,021	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)	\$ 3,789,444	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-Jan-05 Ending: 31-Dec-05

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,920,869	1
2	Discounts and Allowances for all Levels	(900,849)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,020,020	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	441,916	6
7	Oxygen	63,569	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 505,485	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	7,789	11
12	Gift and Coffee Shop	10,448	12
13	Barber and Beauty Care	4,715	13
14	Non-Patient Meals	18,751	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	218,752	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	23,122	20
21	Other Medical Services	126,244	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 409,821	23
D. Non-Operating Revenue			
24	Contributions	184,861	24
25	Interest and Other Investment Income***	13,406	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 198,267	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	188,795	28
28a	Other Income	65,373	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 254,168	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,387,761	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,090,492	31
32	Health Care	2,962,370	32
33	General Administration	1,461,152	33
B. Capital Expense			
34	Ownership	276,634	34
C. Ancillary Expense			
35	Special Cost Centers	194,604	35
36	Provider Participation Fee	57,488	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,042,740	40
41	Income before Income Taxes (line 30 minus line 40)**	345,021	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 345,021	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
 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	1,900	2,080	\$ 54,115	\$ 26.02	1
2	Assistant Director of Nursing	1,885	2,077	41,851	20.15	2
3	Registered Nurses	22,259	24,421	599,482	24.55	3
4	Licensed Practical Nurses	17,874	19,148	372,057	19.43	4
5	CNAs & Orderlies	104,636	112,323	1,367,465	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,056	1,116	10,145	9.09	8
9	Activity Director	1,851	1,950	23,144	11.87	9
10	Activity Assistants	7,807	8,443	92,078	10.91	10
11	Social Service Workers	6,093	6,701	80,215	11.97	11
12	Dietician					12
13	Food Service Supervisor	1,945	2,080	29,856	14.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,974	27,932	255,202	9.14	15
16	Dishwashers					16
17	Maintenance Workers	7,447	8,110	109,927	13.55	17
18	Housekeepers	16,887	17,126	167,780	9.80	18
19	Laundry	7,520	8,108	72,572	8.95	19
20	Administrator	760	760	22,381	29.45	20
21	Assistant Administrator					21
22	Other Administrative	1,840	2,080	78,034	37.52	22
23	Office Manager	1,816	2,080	41,376	19.89	23
24	Clerical	8,050	8,594	119,396	13.89	24
25	Vocational Instruction	131	131	3,216	24.55	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>	2,984	3,424	39,712	11.60	33
34	TOTAL (lines 1 - 33)	240,715	258,684	\$ 3,580,004 *	\$ 13.84	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	177	\$ 7,860	1.3	35
36	Medical Director	3	400	9.3	36
37	Medical Records Consultant	4	235	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	10.3	39
40	Physical Therapy Consultant	60	3,445	10a.3	40
41	Occupational Therapy Consultant	7	395	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	21	1,217	10a.3	43
44	Activity Consultant	15	767	11.3	44
45	Social Service Consultant	28	1,460	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	326	\$ 16,678		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	47	\$ 2,084	10.3	50
51	Licensed Practical Nurses	199	6,748	10.3	51
52	Certified Nurse Assistants/Aides	186	3,204	10.3	52
53	TOTAL (lines 50 - 52)	432	\$ 12,036		53

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

31-Dec-05

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	Carpentry	May 2001	\$ 1,244		\$ 249	\$ 249	\$ 249	\$ 249	\$ 124	\$	\$	\$	\$
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19													
20	TOTALS		\$ 1,244		\$ 249	\$ 249	\$ 249	\$ 249	\$ 124	\$	\$	\$	\$

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01-Jan-05

Ending:

31-Dec-05

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 4,822
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 5.29
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,790 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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 during this cost report period. \$ 57,488
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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 benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 18,751
- (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? 100% of Progr.
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.