

		FOR BHF USE					

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2006
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT FOR
 LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2006)

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>HFS ID Number: <u>37-1194111001</u></p> <p>Date of Initial License for Current Owners: <u>Jun-88</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <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 _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2006</u> to <u>12/31/2006</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 style="width:100%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Keith Swartzentruber</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Executive Director</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # ()</td> <td></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) <u>()</u> Fax # ()	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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Facility Name & ID Number Snyder Village Health Center# 0033647 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	<u>105</u>	Skilled (SNF)	<u>105</u>	<u>38,325</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>105</u>	TOTALS	<u>105</u>	<u>38,325</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,414</u>	<u>12,915</u>	<u>3,728</u>	<u>23,057</u>	8
9	SNF/PED					9
10	ICF	<u>2,494</u>	<u>8,747</u>		<u>11,241</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,908</u>	<u>21,662</u>	<u>3,728</u>	<u>34,298</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.49%

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)

NoneF. 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 Jun-88

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

YES Date 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 3,728Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Snyder Village Health Center # 003364/ Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	294,045	-	29,339	323,384	-	323,384	-	323,384		1
2	Food Purchase		223,350		223,350	-	223,350	(40,140)	183,210		2
3	Housekeeping	167,066	20,785	839	188,690	-	188,690	(12,836)	175,854		3
4	Laundry	74,276	14,836	70	89,182	-	89,182	-	89,182		4
5	Heat and Other Utilities			144,229	144,229	-	144,229	(51,706)	92,523		5
6	Maintenance	138,666	28,928	27,277	194,871	(1,350)	193,521	(876)	192,645		6
7	Other (specify):*				-		-		-		7
8	TOTAL General Services	674,053	287,899	201,754	1,163,706	(1,350)	1,162,356	(105,559)	1,056,797		8
	B. Health Care and Programs										
9	Medical Director	-	-	275	275	-	275	-	275		9
10	Nursing and Medical Records	2,468,157	77,286	42,268	2,587,711	-	2,587,711	(16,564)	2,571,147		10
10a	Therapy	11,153	2,119	195,183	208,455	-	208,455	-	208,455		10a
11	Activities	125,384	6,196	661	132,241	-	132,241	-	132,241		11
12	Social Services	81,109	992	1,408	83,509	-	83,509	(9,039)	74,470		12
13	CNA Training	4,044	-	400	4,444	-	4,444	-	4,444		13
14	Program Transportation	-	-	-	-	-	-	-	-		14
15	Other (specify):*				-		-		-		15
16	TOTAL Health Care and Programs	2,689,847	86,593	240,195	3,016,635	-	3,016,635	(25,603)	2,991,032		16
	C. General Administration										
17	Administrative	146,637	-	-	146,637	-	146,637	-	146,637		17
18	Directors Fees				-		-		-		18
19	Professional Services			37,622	37,622	(22)	37,600	(5,000)	32,600		19
20	Dues, Fees, Subscriptions & Promotions			42,141	42,141	3,605	45,746	(25,723)	20,023		20
21	Clerical & General Office Expenses	207,086	23,529	46,660	277,275	3,490	280,765	(214,786)	65,979		21
22	Employee Benefits & Payroll Taxes			902,399	902,399	-	902,399	-	902,399		22
23	Inservice Training & Education			1,772	1,772	(500)	1,272	-	1,272		23
24	Travel and Seminar			9,962	9,962	(6,573)	3,389	-	3,389		24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-		25
26	Insurance-Prop.Liab.Malpractice			84,926	84,926	-	84,926	-	84,926		26
27	Other (specify):*				-		-		-		27
28	TOTAL General Administration	353,723	23,529	1,125,482	1,502,734	-	1,502,734	(245,509)	1,257,225		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,717,623	398,021	1,567,431	5,683,075	(1,350)	5,681,725	(376,671)	5,305,054		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.

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			182,022	182,022		182,022	(1,493)	180,529		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			83,480	83,480		83,480	(75,090)	8,390		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			1,003	1,003	1,350	2,353		2,353		35
36	Other (specify):*										36
37	TOTAL Ownership			266,505	266,505	1,350	267,855	(76,583)	191,272		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		168,989	10,709	179,698		179,698		179,698		39
40	Barber and Beauty Shops			278	278		278		278		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		168,989	68,475	237,464		237,464		237,464		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,717,623	567,010	1,902,411	6,187,044		6,187,044	(453,254)	5,733,790		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: 1/1/2006

Ending: 12/31/2006

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	(19,326)	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	(1,493)	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	(22,921)	20.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,707)	20.3		28
29	Other-Attach Schedule	(406,807)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (453,254)		\$	30

BHF USE ONLY					
48		49		50	
				51	
				52	

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

		1	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))	\$ (453,254)		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.

		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: 1/1/2006 Ending: 12/31/2006

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.

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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:

1/1/2006

Ending:

12/31/2006

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	2	3	4	5	6		7	8	9	10
						Amount of Note	Reporting Period Interest Expense				
Name of Lender	Related**	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)			
	YES	NO									
A. Directly Facility Related											
Long-Term											
1	Commerce Bank	X	Building	\$12,758.00	Aug-87	\$ 3,450,000	\$ 1,156,298	Sep-26	0.0507	\$ 62,757	1
2	CDAP Village Metamora	X	Building	\$4,340.00		614,000	140,232		0.0375	6,105	2
3	Commerce Bank	X	Bldg Construction	\$4,855.00	Feb-01	500,000	87,462	May-07	0.0825	9,160	3
4	Commerce Bank	X	Patient Transport Vehicle	\$562.00	Nov-02	29,900	5,626	Oct-07	0.0825	705	4
5	Woodford County	X	Bldg Construction	\$1,887.00	Dec-00	100,000		Nov-05	0.0500		5
Working Capital											
6	Gift Annuity	X	Building	\$510.00		84,000	57,845		0.0675	4,753	6
7											7
8										(75,090)	8
9	TOTAL Facility Related			\$24,912.00		\$ 4,777,900	\$ 1,447,462			\$ 8,390	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	\$ 1,447,462			\$ 8,390	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to the Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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 x 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Snyder Village Health Center# 0033647

Report Period Beginning:

1/1/2006 Ending:12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,870 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories OneC. 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 Ft²Snyder Village Retirement Community Cottages - 135 Cottages @ 300,000 Ft²Snyder Village Assisted Living - 41 Apartments @ 21,000 Ft²F. 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:

1/1/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61		Jan-88	Jan-88	\$ 1,929,231	\$ 42,872	45	\$ 42,872	\$	\$ 793,130	4
5			Jan-92	Jan-92	127,495	2,833	45	2,833		41,317	5
6			Jan-92	Jan-92	33,830	1,353	25	1,353		19,169	6
7	18		Jan-94	Jan-94	600,872	13,353	45	13,353		171,361	7
8	26		Jan-94	Jan-94	1,256,597	27,924	45	27,924		337,418	8
		Improvement Type**									
9		Fire Control System		Oct-89	5,152	258	20	258		4,446	9
10		Century Tub		Oct-89	7,694		10			7,694	10
11		Asphalt		Jul-90	1,820	91	20	91		1,502	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		1,056	15
16		Door Locks		Apr-92	1,200	60	20	60		885	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		15,432	19
20		Services Windows		Mar-95	201,662	4,481	45	4,481		51,031	20
21		Landscaping		Jan-95	13,848	692	20	692		6,132	21
22		Canopy		Dec-95	1,102	55	20	55		610	22
23		Electrical Maintenance		Sep-95	595	40	15	40		451	23
24		Door Locks		Aug-95	505	34	15	34		386	24
25		Front Canopy		Sep-96	44,945	999	45	999		9,473	25
26		Tower		May-96	7,360	368	20	368		3,925	26
27		Door Open		Sep-96	3,344	223	10	225	2	3,344	27
28		Landscaping		Jul-97	1,500	75	20	75		713	28
29		Front Door Wiring		Mar-97	1,396	70	20	70		687	29
30		Kelly Glass		Jan-98	3,527	176	20	176		1,585	30
31		MTCO Phone System		Aug-98	18,914	757	25	757		5,307	31
32		Carpet		Nov-98	15,719	1,572	10	1,572		12,838	32
33		Heater		Apr-99	1,784	178	10	178		1,380	33
34		Security Camera		Jan-99	2,510	167	15	167		1,337	34
35		Motion Detector		Jan-99	790		10	79	79	632	35
36		Shelving		Jan-99	673		10	67	67	536	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:

1/1/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1	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	\$ 2,360	37
38	Blacktop	Dec-00	21,736	1,087	20	1,087		6,612	38
39	Sunroom	May-00	86,410	1,920	45	1,920		12,477	39
40	Generator	Feb-00	36,206	1,810	20	1,810		11,691	40
41	Time Clock	Mar-00	7,789		5			7,789	41
42	Motion Detector	May-00	5,714	571	10	571		3,807	42
43	Nursing Office Addition	Apr-01	751,810	16,707	45	16,707		91,979	43
44	Sunroom	Jan-01	11,315	1,132	10	1,132		6,792	44
45	Tower	Jun-01	5,640	564	10	564		3,149	45
46	Door	Nov-01	2,545	255	10	255		1,317	46
47	Carpet	Nov-01	3,529	353	10	353		1,824	47
48	Nurse Office Addition	Apr-01	4,943	247	20	247		1,420	48
49	Blacktop	Nov-01	12,054	603	20	603		3,116	49
50	Roof	Jun-02	36,779	2,452	15	2,452		11,239	50
51	Hall 2 Room Alert	Feb-02	5,015	1,003	5	1,003		4,927	51
52	Door, Tile, Drapes, Wall	Mar-03	4,557	570	8	570		2,186	52
53	Door	Feb-04	1,640	547	3	547		1,594	53
54	Roam Alert	Apr-04	4,488	898	5	898		2,470	54
55	Carpet Hall 2	Aug-04	856	171	5	171		413	55
56	Drapery	Apr-04	2,335	467	5	467		1,285	56
57	Heat Pump	Apr-05	2,165	216	10	217	1	380	57
58	Water Heater	Jun-05	4,240	424	10	424		671	58
59	Therapy room door	Oct-05	755	151	5	151		189	59
60	Hall 1 Nurses Station	Oct-05	9,010	451	20	451		563	60
61	Service Door	Nov-05	950	317	3	317		369	61
62	Blacktop Sealcoat	Oct-05	3,373	675	5	675		843	62
63	Disposal unit	Feb-06	2,221	204	10	203	(1)	203	63
64	Heat pump	Apr-06	4,981	374	10	374		374	64
65	Air conditioning unit	Jun-06	1,183	147	5	138	(9)	138	65
66	Heat pump	Sep-06	4,260	142	10	141	(1)	141	66
67	Hall carpeting	Oct-06	29,587	740	10	738	(2)	738	67
68	Sidewalk	May-06	900	30	20	30		30	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	34

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

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		
1	Totals from Page 12B, Carried Forward	\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460		34

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

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	
1	Totals from Page 12C, Carried Forward		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	34

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

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	
1	Totals from Page 12D, Carried Forward		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	34

**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:

1/1/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	34

**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:

1/1/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,394,043	\$ 135,206		\$ 135,705	\$ 499	\$ 1,685,460	34

**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: 1/1/2006 Ending: 12/31/2006

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	\$ 213,705	\$ 33,031	\$ 33,031	\$	various	\$ 157,414	71
72	Current Year Purchases	33,491	4,074	4,074		various	4,074	72
73	Fully Depreciated Assets	629,575				various	629,575	73
74								74
75	TOTALS	\$ 876,771	\$ 37,105	\$ 37,105	\$		\$ 791,063	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	4,728	4,729	1	10	51,573	78
79	Patient Transport	2000 Ford Van	Sep-02	29,900	4,983	2,990	(1,993)	10	29,218	79
80	TOTALS			\$ 150,757	\$ 9,711	\$ 7,719	\$ (1,992)		\$ 150,075	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)	\$ 6,465,871	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 182,022	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,529	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,493)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,626,598	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	\$ 27,300	92
93			93
94			94
95		\$ 27,300	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: \$ 2,353 Description: Postage Meter \$1,003 and Copier \$1,350

(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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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 CNA <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 CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		4,044		4,044
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		400		400
9	TOTALS	\$	\$ 4,444	\$	\$ 4,444
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,444		

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	1
2. From other facilities (f)	
TOTAL TRAINED	9

- (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.

Facility Name & ID Number Snyder Village Health Center# 0033647 Report Period Beginning:

1/1/2006 Ending: 12/31/2006

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	226	\$ 15,341	\$	226	\$ 15,341	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		269	19,906		269	19,906	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		493	32,785		493	32,785	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				100,724		100,724	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): <u>Medical Supplies</u>	39.2					68,265		68,265	13
14	TOTAL			\$	988	\$ 68,032	\$ 168,989	988	\$ 237,021	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.

Facility Name & ID Number Snyder Village Health Center

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Report Period Beginning: 1/1/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of #####

(last day of reporting year)

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	\$ 178,816	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (17,087))	1,116,859		3
4	Supply Inventory (priced at FIFO)	28,144		4
5	Short-Term Investments	262,690		5
6	Prepaid Insurance	56,920		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)	\$ 1,643,429	\$	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	5,160,209		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,196,775		16
17	Accumulated Depreciation (book methods)	(2,524,170)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Resident in Need / Endowment	459,807		22
23	Other(specify): Construction in Progress	27,300		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,364,221	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,007,650	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ (127,684)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(175,100)		30
31	Accrued Taxes Payable (excluding real estate taxes)	73		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	(150,403)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (453,114)	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	(1,447,462)		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)	\$ (1,447,462)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (1,900,576)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,107,074)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (6,007,650)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,789,444	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,789,444	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	317,630	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)	\$ 317,630	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)	\$ 4,107,074	24 *

* This must agree with page 17, line 47.

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Report Period Beginning: 1/1/2006

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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		2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,872,738	1
2	Discounts and Allowances for all Levels	(860,279)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,012,459	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	540,557	6
7	Oxygen	47,225	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 587,782	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	600	11
12	Gift and Coffee Shop	9,140	12
13	Barber and Beauty Care	4,685	13
14	Non-Patient Meals	19,326	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	221,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,298	20
21	Other Medical Services	127,021	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 397,678	23
	D. Non-Operating Revenue		
24	Contributions	127,993	24
25	Interest and Other Investment Income***	108,601	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 236,594	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	259,144	28
28a	Other Income	11,017	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 270,161	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,504,674	30

1		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,163,706	31
32	Health Care	3,016,635	32
33	General Administration	1,502,734	33
	B. Capital Expense		
34	Ownership	266,505	34
	C. Ancillary Expense		
35	Special Cost Centers	179,976	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)*	\$ 6,187,044	40
41	Income before Income Taxes (line 30 minus line 40)**	317,630	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 317,630	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.

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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	1,880	2,080	\$ 56,019	\$ 26.93	1
2	Assistant Director of Nursing	1,893	2,082	44,929	21.58	2
3	Registered Nurses	18,195	19,375	510,316	26.34	3
4	Licensed Practical Nurses	20,092	21,272	477,776	22.46	4
5	CNAs & Orderlies	81,775	106,016	1,335,842	12.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,032	1,128	11,153	9.89	8
9	Activity Director	1,924	2,080	30,328	14.58	9
10	Activity Assistants	6,878	9,055	95,056	10.50	10
11	Social Service Workers	5,099	6,175	81,109	13.14	11
12	Dietician					12
13	Food Service Supervisor	1,753	1,892	27,935	14.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,035	27,665	266,109	9.62	15
16	Dishwashers					16
17	Maintenance Workers	6,557	9,368	138,666	14.80	17
18	Housekeepers	12,429	16,799	167,066	9.94	18
19	Laundry	6,544	7,844	74,276	9.47	19
20	Administrator	1,824	2,080	62,453	30.03	20
21	Assistant Administrator					21
22	Other Administrative	1,932	2,080	84,184	40.47	22
23	Office Manager	1,567	2,024	42,877	21.19	23
24	Clerical	7,063	7,830	125,089	15.98	24
25	Vocational Instruction	153	153	4,044	26.43	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>	3,088	3,390	43,276	12.77	33
34	TOTAL (lines 1 - 33)	203,713	250,386	\$ 3,678,503 *	\$ 14.69	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	159	\$ 7,432	1.3	35
36	Medical Director	3	275	9.3	36
37	Medical Records Consultant	12	675	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	10.3	39
40	Physical Therapy Consultant	16	910	10a.3	40
41	Occupational Therapy Consultant	26	1,403	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	24	1,386	10a.3	43
44	Activity Consultant	8	466	11.3	44
45	Social Service Consultant	27	1,408	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	286	\$ 14,855		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	41	\$ 1,482	10.3	50
51	Licensed Practical Nurses	381	13,486	10.3	51
52	Certified Nurse Assistants/Aides	1,365	23,522	10.3	52
53	TOTAL (lines 50 - 52)	1,787	\$ 38,490		53

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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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$								
2	Carpentry	May 2001	1244		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		\$ 249	\$ 249	\$ 249	\$ 124	\$	\$	\$	\$

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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? 6.7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,788 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. \$ 19,326
- (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 Program
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? N/A
g. Does the facility transport residents to and from day training? No _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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.