

Facility Name & ID Number Snyder Village Health Center# 0033647 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 Patient Days by Level of Care and Primary Source of Payment			5
		Medicaid Recipient	Private Pay	Other	
8	SNF	<u>365</u>	<u>730</u>	<u>3,289</u>	<u>4,384</u>
9	SNF/PED				
10	ICF	<u>9,215</u>	<u>22,028</u>		<u>31,243</u>
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>9,580</u>	<u>22,758</u>	<u>3,289</u>	<u>35,627</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.96%

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 6/1988

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/1988 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 3,289

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	307,173		28,464	335,637		335,637		335,637		1
2	Food Purchase		235,488		235,488		235,488	(42,352)	193,136		2
3	Housekeeping	179,542	22,168	773	202,483		202,483	(22,301)	180,182		3
4	Laundry	76,070	11,453	130	87,653		87,653		87,653		4
5	Heat and Other Utilities			142,564	142,564		142,564	(50,669)	91,895		5
6	Maintenance	142,754	28,627	30,709	202,090		202,090	(1,329)	200,761		6
7	Other (specify):*										7
8	TOTAL General Services	705,539	297,736	202,640	1,205,915		1,205,915	(116,650)	1,089,265		8
	B. Health Care and Programs										
9	Medical Director			300	300		300		300		9
10	Nursing and Medical Records	2,593,355	100,055	59,696	2,753,106	(7,065)	2,746,041	(16,007)	2,730,034		10
10a	Therapy	11,317	1,228	213,990	226,535		226,535		226,535		10a
11	Activities	125,351	11,408	230	136,989		136,989		136,989		11
12	Social Services	84,500	764	1,532	86,796		86,796	(10,122)	76,674		12
13	CNA Training			895	895	7,065	7,960		7,960		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,814,523	113,455	276,643	3,204,621		3,204,621	(26,129)	3,178,492		16
	C. General Administration										
17	Administrative	154,962			154,962		154,962		154,962		17
18	Directors Fees										18
19	Professional Services			40,254	40,254	(21)	40,233		40,233		19
20	Dues, Fees, Subscriptions & Promotions			48,201	48,201	580	48,781	(25,624)	23,157		20
21	Clerical & General Office Expenses	231,639	26,578	64,551	322,768	129	322,897	(236,138)	86,759		21
22	Employee Benefits & Payroll Taxes			975,010	975,010	(580)	974,430		974,430		22
23	Inservice Training & Education			1,407	1,407		1,407		1,407		23
24	Travel and Seminar			3,912	3,912	(108)	3,804		3,804		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			69,910	69,910		69,910		69,910		26
27	Other (specify):*										27
28	TOTAL General Administration	386,601	26,578	1,203,245	1,616,424		1,616,424	(261,762)	1,354,662		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,906,663	437,769	1,682,528	6,026,960		6,026,960	(404,542)	5,622,418		29

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

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

Facility Name & ID Number Snyder Village Health Center #0033647 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			186,470	186,470		186,470	(3,367)	183,103		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			68,675	68,675		68,675	(35,303)	33,372		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			744	744		744		744		35
36	Other (specify):*										36
37	TOTAL Ownership			255,889	255,889		255,889	(38,670)	217,219		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		157,179	9,842	167,021		167,021		167,021		39
40	Barber and Beauty Shops			209	209		209		209		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		157,179	67,539	224,718		224,718		224,718		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,906,663	594,948	2,005,956	6,507,567		6,507,567	(443,212)	6,064,355		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: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(20,730)	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	(3,367)	30.3		9
10 Interest and Other Investment Income	(35,303)	32.3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising	(2,604)	20.3		28
29 Other-Attach Schedule	(381,208)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (443,212)		\$	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))	\$ (443,212)		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					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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: 01/01/07 Ending: 12/31/07

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Commerce Bank		X	Building	12,758.00	08/01/87	\$ 3,450,000	\$ 1,033,376	09/01/26	0.0507	\$ 53,673	1
2	CDAP Village Metamora		X	Building	4,340.00	Various	614,000	109,809	Various	0.0375	5,087	2
3	Commerce Bank		X	Bldg Construction	4,855.00	02/01/01	500,000	35,885	05/31/08	0.0825	4,939	3
4	Commerce Bank		X	Patient Transport Vehicle	562.00	11/01/02	29,900		10/01/07	0.0825	223	4
5					-					-		5
	Working Capital											
6	Gift Annuity		X	Building	510.00	Various	84,000	53,783	Various	0.0675	4,753	6
7					-					-		7
8					-				Less: Interest Income		(35,303)	8
9	TOTAL Facility Related				23,025.00		\$ 4,677,900	\$ 1,232,853			\$ 33,372	9
	B. Non-Facility Related*											
10					-					-		10
11					-					-		11
12					-					-		12
13					-					-		13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,677,900	\$ 1,232,853			\$ 33,372	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.)

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2006 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 2007 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:				
	2002	_____	8	
	2003	_____	9	
	2004	_____	10	
	2005	_____	11	
	2006	_____	12	
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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: 01/01/07 Ending: 12/31/07

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 - 135 Cottages @ 300,000 Ft2

Snyder Village Assisted Living - 41 Apartments @ 21,000 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	155,422	1987	\$ 43,000	1
2	Nursing Home		2001	1,300	2
3	TOTALS			\$ 44,300	3

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 BHF 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	\$ 0	\$ 836,002	4
5		Jan-92	Jan-92	127,495	2,833	45	2,833	(0)	44,150	5
6		Jan-92	Jan-92	33,830	1,353	25	1,353	(0)	20,522	6
7	18	Jan-94	Jan-94	600,872	13,353	45	13,353		184,714	7
8	26	Jan-94	Jan-94	1,256,597	27,924	45	27,924		365,342	8
Improvement Type**										
9	Fire Control System		Oct-89	5,152	258	20	258		4,704	9
10	Century Tub		Oct-89	7,694		10			7,694	10
11	Asphalt		Jul-90	1,820	91	20	91		1,593	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		1,126	15
16	Door Locks		Apr-92	1,200	60	20	60		945	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		16,709	19
20	Services Windows		Mar-95	201,662	4,481	45	4,481		55,512	20
21	Landscaping		Jan-95	13,848	692	20	692	(0)	6,824	21
22	Canopy		Dec-95	1,102	55	20	55		665	22
23	Electrical Maintenance		Sep-95	595	40	15	40	0	491	23
24	Door Locks		Aug-95	505	34	15	34		420	24
25	Front Canopy		Sep-96	44,945	999	45	999		10,472	25
26	Tower		May-96	7,360	368	20	368		4,293	26
27	Door Open		Sep-96	3,344		10			3,344	27
28	Landscaping		Jul-97	1,500	75	20	75		788	28
29	Front Door Wiring		Mar-97	1,396	70	20	70	0	757	29
30	Kelly Glass		Jan-98	3,527	176	20	176	(0)	1,761	30
31	MTCO Phone System		Aug-98	18,914	757	25	757		6,064	31
32	Carpet		Nov-98	15,719	1,572	10	1,572		14,410	32
33	Heater		Apr-99	1,784	178	10	178		1,558	33
34	Security Camera		Jan-99	2,510	167	15	167	(0)	1,504	34
35	Motion Detector		Jan-99	790		10	79	79	711	35
36	Shelving		Jan-99	673		10	67	67	603	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Snyder Village Health Center# 0033647

Report Period Beginning:

01/01/07 Ending: 12/31/07

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	\$ 2,723	37
38	Blacktop	Dec-00	21,736	1,087	20	1,087		7,699	38
39	Sunroom	May-00	86,410	1,920	45	1,920	(0)	14,397	39
40	Generator	Feb-00	36,206	1,810	20	1,810	(0)	13,501	40
41	Time Clock	Mar-00	7,789		5			7,789	41
42	Motion Detector	May-00	5,714	571	10	571		4,378	42
43	Nursing Office Addition	Apr-01	751,810	16,707	45	16,707	0	108,686	43
44	Sunroom	Jan-01	11,315	1,132	10	1,132	0	7,924	44
45	Tower	Jun-01	5,640	564	10	564	(0)	3,713	45
46	Door	Nov-01	2,545	255	10	255		1,572	46
47	Carpet	Nov-01	3,529	353	10	353		2,177	47
48	Nurse Office Addition	Apr-01	4,943	247	20	247	(0)	1,667	48
49	Blacktop	Nov-01	12,054	603	20	603	0	3,719	49
50	Roof	Jun-02	36,779	2,452	15	2,452		13,691	50
51	Hall 2 Room Alert	Feb-02	5,015	84	5	88	4	5,015	51
52	Door, Tile, Drapes, Wall	Mar-03	4,557	570	8	570	0	2,756	52
53	Door	Feb-04	1,640	46	3	46		1,640	53
54	Roam Alert	Apr-04	4,488	898	5	898		3,368	54
55	Carpet Hall 2	Aug-04	856	171	5	171		584	55
56	Draperly	Apr-04	2,335	467	5	467		1,752	56
57	Heat Pump	Apr-05	2,165	217	10	217		597	57
58	Water Heater	Jun-05	4,240	424	10	424		1,095	58
59	Therapy room door	Oct-05	755	151	5	151		340	59
60	Hall 1 Nurses Station	Oct-05	9,010	451	20	451	0	1,014	60
61	Service Door	Nov-05	950	317	3	317		686	61
62	Blacktop Sealcoat	Oct-05	3,373	675	5	675		1,518	62
63	Disposal unit	Feb-06	2,221	222	10	222		425	63
64	Heat pump	Apr-06	4,981	498	10	498		872	64
65	Air conditioning unit	Jun-06	1,183	237	5	237		375	65
66	Heat pump	Sep-06	4,260	426	10	426		567	66
67	Hall carpeting	Oct-06	29,587	2,959	10	2,959	0	3,697	67
68	Sidewalk	May-06	900	45	20	45		75	68
69	Alarm system	Jan-07	3,304	661	5	659	(2)	659	69
70	TOTAL (lines 4 thru 69)		\$ 5,397,347	\$ 136,975		\$ 137,486	\$ 511	\$ 1,822,946	70

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
1	Totals from Page 12A, Carried Forward	\$ 5,397,347	\$ 136,975		\$ 137,486	\$ 511	\$ 1,822,946	1
2	Heat pump	Jan-07 9,181	493	10	916	423	916	2
3	Hall 2 flooring	Aug-07 27,466	1,144	10	1,144		1,144	3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	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:

01/01/07 Ending:

12/31/07

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	
1	Totals from Page 12B, Carried Forward	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	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:

01/01/07 Ending: 12/31/07

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	
1	Totals from Page 12C, Carried Forward	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	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:

01/01/07 Ending: 12/31/07

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	
1	Totals from Page 12D, Carried Forward	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	34

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

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
1	Totals from Page 12E, Carried Forward	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	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:

01/01/07

Ending:

12/31/07

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	
1	Totals from Page 12F, Carried Forward	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,433,994	\$ 138,612		\$ 139,546	\$ 934	\$ 1,825,006	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: 01/01/07 Ending: 12/31/07

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	\$ 172,987	\$ 34,152	\$ 34,152	\$	various	\$ 179,108	71
72	Current Year Purchases	81,429	8,723	8,723		various	8,723	72
73	Fully Depreciated Assets	646,107				various	646,107	73
74								74
75	TOTALS	\$ 900,523	\$ 42,875	\$ 42,875	\$		\$ 833,938	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	01/01/99	\$ 22,259	\$	\$	\$	5	\$ 22,259	76
77	Resident Transportation	1994 Van	01/01/94	47,025				10	47,025	77
78	Resident Transportation	1996 Van	01/01/96	51,573				10	51,573	78
79	Patient Transport	2000 Ford Van	09/01/02	29,900	4,983	682	(4,301)	10	29,900	79
80	TOTALS			\$ 150,757	\$ 4,983	\$ 682	\$ (4,301)		\$ 150,757	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 6,529,574	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 186,470	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 183,103	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,367)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,809,701	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	\$ 65,146	92
93			93
94			94
95		\$ 65,146	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: \$ 744 Description: Postage Meter \$744

(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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>40</u>
		HOURS PER CNA <u>80</u>	

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

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)		7,065		7,065
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		895		895
9	TOTALS	\$	\$ 7,960	\$	\$ 7,960
10	SUM OF line 9, col. 1 and 2 (e)	\$	7,960		

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	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	17

- (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:

01/01/07 Ending: 12/31/07

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$	245	\$ 16,236				245	\$ 16,236	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		485	34,497				485	34,497	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs		429	28,977				429	28,977	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					94,957			94,957	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						62,222			62,222	13
14	TOTAL			\$	1,159	\$ 79,710		\$ 157,179		1,159	\$ 236,889	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# 0033647Report Period Beginning: 01/01/07Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007 (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	\$ 363,450	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (22,012))	1,000,578		3
4	Supply Inventory (priced at FIFO)	32,474		4
5	Short-Term Investments	270,803		5
6	Prepaid Insurance	77,091		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)	\$ 1,744,396	\$	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	1,318,154		16
17	Accumulated Depreciation (book methods)	(2,710,640)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	558,174		22
23	Other(specify): <u>Construction in Progress</u>	65,146		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,435,343	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,179,739	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (118,088)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(199,623)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(36,212)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Employee Benefits Payable</u>	(131,139)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (485,062)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(1,232,853)		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)	\$ (1,232,853)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (1,717,915)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,461,824)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (6,179,739)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,107,074	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(6,099)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,100,975	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	360,849	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 360,849	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)	\$ 4,461,824	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 6,351,548	1
2	Discounts and Allowances for all Levels	(1,103,151)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,248,397	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	636,120	6
7	Oxygen	46,500	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 682,620	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,200	11
12	Gift and Coffee Shop	9,474	12
13	Barber and Beauty Care	4,346	13
14	Non-Patient Meals	20,730	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	229,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,000	20
21	Other Medical Services	137,495	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 417,637	23
D. Non-Operating Revenue			
24	Contributions	155,916	24
25	Interest and Other Investment Income***	77,998	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 233,914	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	275,326	28
28a	Other Income	10,522	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 285,848	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,868,416	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,205,915	31
32	Health Care	3,204,621	32
33	General Administration	1,616,424	33
B. Capital Expense			
34	Ownership	255,889	34
C. Ancillary Expense			
35	Special Cost Centers	167,230	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)*	\$ 6,507,567	40
41	Income before Income Taxes (line 30 minus line 40)**	360,849	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 360,849	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

0033647

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,916	2,080	\$ 63,182	\$ 30.38	1
2	Assistant Director of Nursing	1,950	2,080	50,741	24.39	2
3	Registered Nurses	15,540	16,928	454,265	26.84	3
4	Licensed Practical Nurses	20,415	21,715	561,533	25.86	4
5	CNAs & Orderlies	101,098	108,834	1,411,896	12.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,041	1,123	11,317	10.08	8
9	Activity Director	1,952	2,080	31,529	15.16	9
10	Activity Assistants	7,430	8,099	93,822	11.58	10
11	Social Service Workers	3,674	4,033	84,500	20.95	11
12	Dietician					12
13	Food Service Supervisor	1,850	2,014	32,786	16.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,762	27,519	274,386	9.97	15
16	Dishwashers					16
17	Maintenance Workers	6,896	7,428	142,754	19.22	17
18	Housekeepers	13,538	14,552	179,542	12.34	18
19	Laundry	7,115	7,740	76,070	9.83	19
20	Administrator	1,872	2,080	64,399	30.96	20
21	Assistant Administrator					21
22	Other Administrative	1,904	2,080	90,563	43.54	22
23	Office Manager	1,888	2,080	47,030	22.61	23
24	Clerical	7,107	7,732	134,431	17.39	24
25	Vocational Instruction	90	90	2,355	26.17	25
26	Academic Instruction	180	180	4,710	26.17	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>	3,114	3,374	44,674	13.24	33
34	TOTAL (lines 1 - 33)	226,332	243,841	\$ 3,856,485 *	\$ 15.82	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	148	\$ 7,069	1.3	35
36	Medical Director	3	300	9.3	36
37	Medical Records Consultant	27	1,723	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	930	10.3	39
40	Physical Therapy Consultant	26	1,481	10a.3	40
41	Occupational Therapy Consultant	28	1,413	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	78	4,501	10a.3	43
44	Activity Consultant	3	150	11.3	44
45	Social Service Consultant	24	1,283	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	349	\$ 18,849		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	259	\$ 8,398	10.3	50
51	Licensed Practical Nurses	1,127	37,154	10.3	51
52	Certified Nurse Assistants/Aides	549	9,522	10.3	52
53	TOTAL (lines 50 - 52)	1,935	\$ 55,074		53

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/07

Ending:

12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Todd Ramlo	Administrator		64,399	Workers' Compensation Insurance	\$ 213,565	IDPH License Fee	\$ 2,195	
Keith Swartzentruber	Executive Director		90,563	Unemployment Compensation Insurance		Advertising: Employee Recruitment	36,253	
				FICA Taxes	282,121	Health Care Worker Background Check	580	
				Employee Health Insurance	332,464	(Indicate # of checks performed 58)		
				Employee Meals		Patient Background Checks	71 710	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of IL	5,000	
				Employee Pension Plan	98,092	Central IL Quality Alliance	2,997	
				Employee Life/Disability	2,723	Dues & Licenses	694	
				Employee Flex Time	13,923	Subscription	352	
				Hep B & Employee Physicals	1,667			
				Employee Appreciation	26,093	Less: Public Relations Expense ()		
				Other Benefits	3,782	Non-allowable advertising	(23,020)	
						Yellow page advertising	(2,604)	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$ 154,962	\$ 974,430		\$ 23,157		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	1,287
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Seminar Expense	2,517
(Attach a copy of any management service agreement)							Entertainment Expense ()	
C. Professional Services								
Vendor/Payee	Type		Amount					
Heinold Banwart LTD	Accounting		16,154					
Robert Rein CPA	Accounting		5,500					
FR&R	Consulting		45					
Davis & Campbell LLC	Legal		968					
Johnson, Bunce & Noble	Legal		1,581					
Adaptasoft, Inc.	Computer		8,272					
Farnsworth Group	Architect		3,380					
Reclassification			21					
Miller, Hall & Triggs	Legal		508					
Designware Systems, Inc.	Computer		2,489					
Chicago Title Insurance Company	Consulting		96					
Evans, Froelich, Beth & Chamley	Legal		1,240					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 40,254	\$			\$ 3,804	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	8 Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Carpentry	May 2001	\$ 1,244		\$ 249	\$ 249	\$ 124	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,244		\$ 249	\$ 249	\$ 124	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/07

Ending:

12/31/07

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 5,000
- (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? N/A
- (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? 7.14
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,862 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. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 20,730
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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. \$ N/A
- (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 \$5,000, 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.