

		FOR BHF USE				

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**2008**  
 STATE OF ILLINOIS  
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
 FOR LONG-TERM CARE FACILITIES  
 (FISCAL YEAR 2008)

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 License 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>37-119411001</u></p> <p>Date of Initial License for Current Owners: <u>6/30/1988</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501 (c) 3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact:        Name: <u>Keith Swartzentruber</u> Telephone Number: <u>(309) 367-4300</u>        Email Address: _____</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>1/1/2008</u> to <u>12/31/2008</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%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Keith Swartzentruber</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Executive Director</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="center">       MAIL TO: BUREAU OF HEALTH FINANCE        ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Keith Swartzentruber</u>		(Title) <u>Executive Director</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) ( ) _____ Fax # ( ) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) ( ) _____ Fax # ( ) _____																																						

Facility Name & ID Number Snyder Village Health Center# 0033647 Report Period Beginning: 1/1/08 Ending: 12/31/08

## 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>38,430</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>38,430</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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>760</u>	<u>1,461</u>	<u>4,018</u>	<u>6,239</u>	8
9	SNF/PED					9
10	ICF	<u>8,261</u>	<u>20,766</u>		<u>29,027</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,021</u>	<u>22,227</u>	<u>4,018</u>	<u>35,266</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.77%

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? YesG. 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 6/30/88J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 6/30/88 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 4,018Medicare 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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	331,758		33,591	365,349		365,349		365,349		1
2	Food Purchase		250,237		250,237		250,237	(49,199)	201,038		2
3	Housekeeping	192,141	23,798	1,300	217,239		217,239	(27,972)	189,267		3
4	Laundry	77,404	14,511	14	91,929		91,929		91,929		4
5	Heat and Other Utilities			170,426	170,426		170,426	(54,255)	116,171		5
6	Maintenance	159,558	38,607	35,725	233,890		233,890	(2,229)	231,661		6
7	Other (specify):*										7
8	TOTAL General Services	760,861	327,153	241,056	1,329,070		1,329,070	(133,654)	1,195,416		8
	B. Health Care and Programs										
9	Medical Director			225	225		225		225		9
10	Nursing and Medical Records	2,646,890	97,128	48,773	2,792,791	(7,137)	2,785,655	(18,012)	2,767,643		10
10a	Therapy	13,564	2,195	263,892	279,651		279,651		279,651		10a
11	Activities	127,273	9,627	875	137,775		137,775		137,775		11
12	Social Services	79,104	1,130	1,321	81,555		81,555	(8,243)	73,312		12
13	CNA Training			720	720	7,137	7,857		7,857		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,866,831	110,080	315,806	3,292,717		3,292,717	(26,255)	3,266,462		16
	C. General Administration										
17	Administrative	173,176			173,176		173,176		173,176		17
18	Directors Fees										18
19	Professional Services			39,031	39,031	(18)	39,013		39,013		19
20	Dues, Fees, Subscriptions & Promotions			70,230	70,230	1,420	71,650	(46,852)	24,798		20
21	Clerical & General Office Expenses	261,263	28,398	85,337	374,998	(7,501)	367,497	(296,158)	71,339		21
22	Employee Benefits & Payroll Taxes			1,025,217	1,025,217	(1,420)	1,023,797		1,023,797		22
23	Inservice Training & Education			1,545	1,545	797	2,342		2,342		23
24	Travel and Seminar			2,418	2,418	6,722	9,140		9,140		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,956	64,956		64,956		64,956		26
27	Other (specify):*										27
28	TOTAL General Administration	434,439	28,398	1,288,734	1,751,571		1,751,571	(343,010)	1,408,561		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,062,131	465,631	1,845,596	6,373,358		6,373,358	(502,920)	5,870,438		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.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Snyder Village Health Center #0033647 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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			191,326	191,326		191,326	(1,154)	190,172			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,200	56,200		56,200	(16,707)	39,493			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,416	5,416		5,416		5,416			35
36	Other (specify):*											36
37	TOTAL Ownership			252,942	252,942		252,942	(17,861)	235,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		206,497	14,317	220,814		220,814		220,814			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,646	57,646		57,646		57,646			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		206,497	71,963	278,460		278,460		278,460			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,062,131	672,128	2,170,501	6,904,760		6,904,760	(520,781)	6,383,979			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:

01/01/08

Ending:

12/31/08

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	(25,435)	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	(1,154)	30.3		9
10	Interest and Other Investment Income	(16,707)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		43.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(477,485)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (520,781)		\$	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) )	\$ (520,781)		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	Medical Supplies		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			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: 01/01/08 Ending: 12/31/08

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: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$ -			\$	\$	1
2	V		-					2
3	V		-					3
4	V		-					4
5	V		-					5
6	V		-					6
7	V		-					7
8	V		-					8
9	V		-					9
10	V		-					10
11	V		-					11
12	V		-					12
13	V		-					13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Commerce Bank		X	Building	\$ 12,758.00	8/1/87	\$ 3,450,000	\$ 906,203	9/1/26	0.0507	\$ 46,454	1
2	CDAP Village Metamora		X	Building	4,340.00	Various	614,000	78,331	Various	0.0375	4,032	2
3	Commerce Bank		X	Bldg Construction	4,855.00	2/1/01	500,000		5/31/08	0.0825	961	3
4					-							4
5					-							5
	<b>Working Capital</b>											
6	Gift Annuity		X	Building	510.00	Various	84,000	49,720	Various	0.0675	4,753	6
7					-							7
8					-				Less: Interest Income		(16,707)	8
9	TOTAL Facility Related				\$22,463.00		\$ 4,648,000	\$ 1,034,254			\$ 39,493	9
	<b>B. Non-Facility Related*</b>											
10					-							10
11					-							11
12					-							12
13					-							13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,648,000	\$ 1,034,254			\$ 39,493	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: 01/01/08 Ending: 12/31/08

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

B. Real Estate Taxes

		<b>Important</b> , 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 2007 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 2008 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			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. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>	\$			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:		2003	_____	8	
		2004	_____	9	
		2005	_____	10	
		2006	_____	11	
		2007	_____	12	
<b>FOR BHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2007	\$			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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/08

Ending:

12/31/08

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 Ft<sup>2</sup>

Snyder Village Retirement Community Cottages - 135 Cottages @ 300,000 Ft<sup>2</sup>

Snyder Village Assisted Living - 41 Apartments @ 21,000 Ft<sup>2</sup>

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	<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	<b>TOTALS</b>	<u>155,422</u>		<u>\$ 44,300</u>	3

Facility Name & ID Number Snyder Village Health Center# 0033647

Report Period Beginning:

01/01/08

Ending: 12/31/08

## 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	1988	1988	\$ 1,929,231	\$ 42,872	45	\$ 42,872	\$	\$ 878,874	4
5		1992	1992	127,495	2,833	45	2,833		46,983	5
6		1992	1992	33,830	1,353	25	1,353		21,875	6
7	18	1994	1994	600,872	13,353	45	13,353		198,067	7
8	26	1994	1994	1,256,597	27,924	45	27,924		393,266	8
Improvement Type**										
9	Fire Control System		1989	5,152	258	20	258		4,962	9
10	Century Tub		1989	7,694		10			7,694	10
11	Asphalt		1990	1,820	91	20	91		1,684	11
12	Alzheimer's Courtyard		1990	3,644		10			3,644	12
13	Heat Exchanger		1990	1,650		10			1,650	13
14	Tub		1991	1,465		10			1,465	14
15	Door Locks		1991	1,400	70	20	70		1,196	15
16	Door Locks		1992	1,200	60	20	60		1,005	16
17	Patio		1992	1,219		10			1,219	17
18	Entrance Light		1993	619		10			619	18
19	Land Improvement		1994	25,546	1,277	20	1,277		17,986	19
20	Services Windows		1995	201,662	4,481	45	4,481		59,993	20
21	Landscaping		1995	13,848	692	20	692		7,516	21
22	Canopy		1995	1,102	55	20	55		720	22
23	Electrical Maintenance		1995	595	40	15	40		531	23
24	Door Locks		1995	505	34	15	34		454	24
25	Front Canopy		1996	44,945	999	45	999		11,471	25
26	Tower		1996	7,360	368	20	368		4,661	26
27	Door Open		1996	3,344		10			3,344	27
28	Landscaping		1997	1,500	75	20	75		863	28
29	Front Door Wiring		1997	1,396	70	20	70		827	29
30	Kelly Glass		1998	3,527	176	20	176		1,937	30
31	MTCO Phone System		1998	18,914	757	25	757		6,821	31
32	Carpet		1998	15,719	1,309	10	1,309		15,719	32
33	Heater		1999	1,784	178	10	178		1,736	33
34	Security Camera		1999	2,510	167	15	167		1,671	34
35	Motion Detector		1999	790		10	79	79	790	35
36	Shelving		1999	673		10	67		670	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:

01/01/08

Ending: 12/31/08

## 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	
37	Automatic Door Open	2000	\$ 5,449	\$	15	\$ 363	\$ 363	\$ 3,086	37
38	Blacktop	2000	21,736	1,087	20	1,087		8,786	38
39	Sunroom	2000	86,410	1,920	45	1,920		16,317	39
40	Generator	2000	36,206	1,810	20	1,810		15,311	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,714	571	10	571		4,949	42
43	Nursing Office Addition	2001	751,810	16,707	45	16,707		125,393	43
44	Sunroom	2001	11,315	1,132	10	1,132		9,056	44
45	Tower	2001	5,640	564	10	564		4,277	45
46	Door	2001	2,545	255	10	255		1,827	46
47	Carpet	2001	3,529	353	10	353		2,530	47
48	Nurse Office Addition	2001	4,943	247	20	247		1,914	48
49	Blacktop	2001	12,054	603	20	603		4,322	49
50	Roof	2002	36,779	2,452	15	2,452		16,143	50
51	Hall 2 Room Alert	2002	5,015		5			5,015	51
52	Door, Tile, Drapes, Wall	2003	4,557	570	8	570		3,326	52
53	Door	2004	1,640		3			1,640	53
54	Roam Alert	2004	4,488	898	5	898		4,266	54
55	Carpet Hall 2	2004	856	171	5	171		755	55
56	Drapery	2004	2,335	467	5	467		2,219	56
57	Heat Pump	2005	2,165	217	10	217		814	57
58	Water Heater	2005	4,240	424	10	424		1,519	58
59	Therapy room door	2005	755	151	5	151		491	59
60	Hall 1 Nurses Station	2005	9,010	451	20	451		1,465	60
61	Service Door	2005	950	264	3	264		950	61
62	Blacktop Sealcoat	2005	3,373	675	5	675		2,193	62
63	Disposal unit	2006	2,221	222	10	222		647	63
64	Heat pump	2006	4,981	498	10	498		1,370	64
65	Air conditioning unit	2006	1,183	237	5	237		612	65
66	Heat pump	2006	4,260	426	10	426		993	66
67	Hall carpeting	2006	29,587	2,959	10	2,959		6,656	67
68	Sidewalk	2006	900	45	20	45		120	68
69	Alarm system	2007	3,304	661	5	661		1,320	69
70	TOTAL (lines 4 thru 69)		\$ 5,397,347	\$ 136,529		\$ 137,038	\$ 442	\$ 1,959,984	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:

01/01/08

Ending: 12/31/08

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	\$ 136,529		\$ 137,038	\$ 509	\$ 1,959,984	1
2	Heat pump	2007 9,181	918	10	918		1,834	2
3	Hall 2 flooring	2007 27,466	2,747	10	2,747		3,891	3
4	Front signage	2008 15,386	385	10	384	(1)	384	4
5	Blacktop	2008 15,488	129	20	127	(2)	127	5
6								6
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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)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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:

01/01/08

Ending: 12/31/08

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	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	1
2								2
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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:

01/01/08

Ending: 12/31/08

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	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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:

01/01/08

Ending: 12/31/08

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	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	1
2								2
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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:

01/01/08

Ending: 12/31/08

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	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	1
2								2
3								3
4								4
5								5
6								6
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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:

01/01/08

Ending: 12/31/08

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	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	1
2								2
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6								6
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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:

01/01/08

Ending: 12/31/08

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 12G, Carried Forward	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	1
2								2
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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:

01/01/08

Ending: 12/31/08

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 12H, Carried Forward	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	1
2								2
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,464,868	\$ 140,708		\$ 141,214	\$ 506	\$ 1,966,220	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: 01/01/08 Ending: 12/31/08

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	\$ 199,584	\$ 42,815	\$ 42,815	\$	various	\$ 213,621	71
72	Current Year Purchases	55,350	6,143	6,143		various	6,143	72
73	Fully Depreciated Assets	663,132				various	663,132	73
74								74
75	TOTALS	\$ 918,066	\$ 48,958	\$ 48,958	\$		\$ 882,896	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	1999	\$ 22,259	\$	\$	\$	5	\$ 22,259	76
77	Resident Transportation	1994 Van	1994	47,025				10	47,025	77
78	Resident Transportation	1996 Van	1996	51,573				10	51,573	78
79	Patient Transport	2000 Ford Van	2002	29,900	1,660		(1,660)	10	29,900	79
80	TOTALS			\$ 150,757	\$ 1,660	\$	\$ (1,660)		\$ 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)	\$ 6,577,991	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,326	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 190,172	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,154)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,999,873	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	\$ 140,180	92
93			93
94			94
95		\$ 140,180	95

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

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

Facility Name & ID Number Snyder Village Health Center

# 0033647

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**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: \$ 5,416 Description: Postage Meter \$920; Copier \$4,496

(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. /2009 \$ \_\_\_\_\_

13. /2010 \$ \_\_\_\_\_

14. /2011 \$ \_\_\_\_\_

\* 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)	1,427	5,709		7,137
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		720		720
9	TOTALS	\$ 1,427	\$ 6,429	\$	\$ 7,857
10	SUM OF line 9, col. 1 and 2 (e)	\$ 7,857			

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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>15</b>

- (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.

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## 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	\$	241	\$ 15,150	\$	241	\$ 15,150	1		
2	Licensed Speech and Language Development Therapist	10a.3	hrs		690	41,367		690	41,367	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	10a.3	hrs		436	27,736		436	27,736	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				145,304		145,304	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Other (specify): <u>Exceptional Care</u>	39.2								12		
13	Other (specify): <u>Medical Supplies</u>	39.2					61,193		61,193	13		
14	TOTAL			\$	1,367	\$ 84,253	\$ 206,497	1,367	\$ 290,750	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: 01/01/08Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 267,169	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (26,672) )	1,034,965		3
4	Supply Inventory (priced at FIFO )	31,214		4
5	Short-Term Investments	275,795		5
6	Prepaid Insurance	249,377		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)	\$ 1,831,848	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,300		13
14	Buildings, at Historical Cost	5,191,082		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,373,505		16
17	Accumulated Depreciation (book methods)	(2,901,966)		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 (sp)	406,712		22
23	Other(specify): <u>Construction in Progress</u>	140,180		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,253,813	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,085,661	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 118,407	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	227,307		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,422		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>	131,562		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 488,698	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,190,257		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)	\$ 1,190,257	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,678,955	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,406,706	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,085,661	\$	48

\*(See instructions.)

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,461,824	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,461,824	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(55,118)	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)	\$ (55,118)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 4,406,706	24 *

\* This must agree with page 17, line 47.

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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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,262,078	1
2	Discounts and Allowances for all Levels	(1,150,170)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,111,908	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	881,534	6
7	Oxygen	43,175	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 924,709	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	8,909	12
13	Barber and Beauty Care	4,414	13
14	Non-Patient Meals	25,435	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	307,323	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,220	20
21	Other Medical Services	144,890	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 512,191	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	144,553	24
25	Interest and Other Investment Income***	(171,468)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (26,915)	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	305,938	28
28a	Other Income	21,811	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 327,749	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,849,642	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,329,070	31
32	Health Care	3,292,717	32
33	General Administration	1,751,571	33
<b>B. Capital Expense</b>			
34	Ownership	252,942	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	220,814	35
36	Provider Participation Fee	57,646	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,904,760	40
41	Income before Income Taxes (line 30 minus line 40)**	(55,118)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (55,118)	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	1,891	2,080	\$ 69,965	\$ 33.64	1
2	Assistant Director of Nursing	1,883	2,080	55,897	26.87	2
3	Registered Nurses	15,749	17,037	497,835	29.22	3
4	Licensed Practical Nurses	18,698	20,184	535,393	26.53	4
5	CNAs & Orderlies	99,370	107,177	1,433,999	13.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,104	1,189	13,564	11.41	8
9	Activity Director	1,897	2,080	32,098	15.43	9
10	Activity Assistants	7,119	7,658	95,175	12.43	10
11	Social Service Workers	3,016	3,276	79,104	24.15	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,080	35,890	17.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,877	27,970	295,868	10.58	15
16	Dishwashers					16
17	Maintenance Workers	11,021	12,005	159,558	13.29	17
18	Housekeepers	13,817	14,738	192,141	13.04	18
19	Laundry	6,990	7,692	77,404	10.06	19
20	Administrator	1,792	2,080	76,009	36.54	20
21	Assistant Administrator					21
22	Other Administrative	2,096	2,080	97,167	46.71	22
23	Office Manager	1,872	2,080	52,567	25.27	23
24	Clerical	7,109	7,778	134,031	17.23	24
25	Vocational Instruction	90	90	2,379	26.43	25
26	Academic Instruction	180	180	4,757	26.43	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	2,791	3,113	46,665	14.99	33
34	TOTAL (lines 1 - 33)	213,234	244,647	\$ 3,987,466 *	\$ 16.30	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	172	\$ 8,568	1.3	35
36	Medical Director	2	225	9.3	36
37	Medical Records Consultant	31	2,011	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	10.3	39
40	Physical Therapy Consultant	35	2,234	10a.3	40
41	Occupational Therapy Consultant	27	1,711	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	69	4,108	10a.3	43
44	Activity Consultant	15	770	11.3	44
45	Social Service Consultant	22	1,164	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	385	\$ 21,691		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	197	\$ 7,862	10.3	50
51	Licensed Practical Nurses	1,044	35,191	10.3	51
52	Certified Nurse Assistants/Aides	82	1,589	10.3	52
53	TOTAL (lines 50 - 52)	1,323	\$ 44,642		53

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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	
				Workers' Compensation Insurance	\$ 303,387	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	2,000	Advertising: Employee Recruitment	59,099	
				FICA Taxes	299,298	Health Care Worker Background Check	1,420	
				Employee Health Insurance	260,686	(Indicate # of checks performed 142 )		
				Employee Meals		Patient Background Checks	72 720	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of IL	5,150	
				Employee Pension Plan	109,756	Central IL Quality Alliance	2,486	
				Employee Life/Disability	2,743	Dues & Licenses	205	
				Employee Flex Time	16,489	Subscription	580	
				Hep B & Employee Physicals	1,484			
				Employee Appreciation	24,496	Less: Public Relations Expense	( )	
				Other Benefits	3,460	Non-allowable advertising	(40,573)	
				Rounding	(2)	Yellow page advertising	(6,279)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 173,176	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 1,023,797		\$ 24,798		
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	3,445
							Seminar Expense	5,695
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 9,140	
C. Professional Services								
Vendor/Payee	Type		Amount					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 39,031					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.

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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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Carpentry	May 2001	\$ 1,244		\$ 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	\$ 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 5,150
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 51,221 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. \$ 57,646  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ 25,435
- (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%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Heinold Banwart Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not completed at this time.
- (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.