



Facility Name & ID Number Snyders-Vaughn Haven

# 0005363 Report Period Beginning: 01/01/08 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 N/A

	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	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,727	4,467	1,486	12,680	8
9	SNF/PED					9
10	ICF	7,568	743		8,311	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,295	5,210	1,486	20,991	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.93%

D. How many bed-hold days during this year were paid by the Department?

None (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

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 1966

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

YES  Date 1992 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 49 and days of care provided 1,486

Medicare Intermediary Wisconsin Physicians Service

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 Snyders-Vaughn Haven # 0005363 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 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
	<b>A. General Services</b>										
1	Dietary	176,565	18,394		194,959			194,959			1
2	Food Purchase		120,547		120,547			120,547	(883)		2
3	Housekeeping	70,085	8,201	1,292	79,578			79,578			3
4	Laundry	45,230	16,779		62,009			62,009			4
5	Heat and Other Utilities			111,533	111,533			111,533			5
6	Maintenance	18,242	16,911	58,467	93,620			93,620			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	310,122	180,832	171,292	662,246			662,246	(883)		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,400	1,400			1,400			9
10	Nursing and Medical Records	763,341	43,064	1,556	807,961			807,961			10
10a	Therapy	33,955		6,823	40,778			40,778			10a
11	Activities	28,113	261		28,374			28,374			11
12	Social Services	24,329		3,880	28,209			28,209			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	849,738	43,325	13,659	906,722			906,722			16
	<b>C. General Administration</b>										
17	Administrative	34,808			34,808			34,808			17
18	Directors Fees										18
19	Professional Services			20,990	20,990			20,990			19
20	Dues, Fees, Subscriptions & Promotions			9,688	9,688			9,688	(1,961)		20
21	Clerical & General Office Expenses	29,034	3,200	25,067	57,301			57,301			21
22	Employee Benefits & Payroll Taxes			183,115	183,115			183,115			22
23	Inservice Training & Education										23
24	Travel and Seminar			149	149			149			24
25	Other Admin. Staff Transportation			668	668			668			25
26	Insurance-Prop.Liab.Malpractice			85,483	85,483			85,483			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	63,842	3,200	325,160	392,202			392,202	(1,961)		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,223,702	227,357	510,111	1,961,170			1,961,170	(2,844)		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Snyders-Vaughn Haven

#0005363

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	
	<b>D. Ownership</b>											
30	Depreciation			48,632	48,632		48,632	33,991	82,623			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,592	54,592		54,592	5,750	60,342			32
33	Real Estate Taxes			38,078	38,078		38,078	(652)	37,426			33
34	Rent-Facility & Grounds			90,000	90,000		90,000	(90,000)				34
35	Rent-Equipment & Vehicles			7,434	7,434		7,434		7,434			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			238,736	238,736		238,736	(50,911)	187,825			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,030		49,030		49,030		49,030			39
40	Barber and Beauty Shops			1,533	1,533		1,533		1,533			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,004	60,004		60,004		60,004			42
43	Other (specify):* <b>Non-allowable cost</b>			69,337	69,337		69,337	(69,337)				43
44	<b>TOTAL Special Cost Centers</b>		49,030	130,874	179,904		179,904	(69,337)	110,567			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,223,702	276,387	879,721	2,379,810		2,379,810	(123,092)	2,256,718			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven

# 0005363

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	(883)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,774)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,079	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,600)	43		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	(49,885)	43		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				28
29	Other-Attach Schedule <u>See Page 5A</u>	(42,036)	Vari.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (96,099)		\$	30

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)	(26,993)	Vari.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (26,993)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (123,092)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Snyders-Vaughn Haven

ID# 0005363

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Medicare treatments	\$ (555)	43	1
2	Interest income	(167)	32	2
3	Lab services	(13,523)	43	3
4	Nonallowable lobbying dues	(1,961)	20	4
5	Non-care related interest expense	(25,178)	32	5
6	Disallow non-care real estate tax & penalties	(652)	33	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(42,036)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Snyders-Vaughn Haven# 0005363

Report Period Beginning:

01/01/08

Ending:

12/31/08

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(883)	0	0	0	0	0	0	0	0	0	0	(883)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(883)</b>	<b>0</b>	<b>(883)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,961)	0	0	0	0	0	0	0	0	0	0	(1,961)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(1,961)</b>	<b>0</b>	<b>(1,961)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(2,844)</b>	<b>0</b>	<b>(2,844)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Snyders-Vaughn Haven

# 0005363

Report Period Beginning:

01/01/08

Ending:

12/31/08

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	2,079	31,912	0	0	0	0	0	0	0	0	0	33,991	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,345)	31,095	0	0	0	0	0	0	0	0	0	5,750	32
33	Real Estate Taxes	(652)	0	0	0	0	0	0	0	0	0	0	(652)	33
34	Rent-Facility & Grounds	0	(90,000)	0	0	0	0	0	0	0	0	0	(90,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(23,918)</b>	<b>(26,993)</b>	<b>0</b>	<b>(50,911)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(69,337)	0	0	0	0	0	0	0	0	0	0	(69,337)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(69,337)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(69,337)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(96,099)</b>	<b>(26,993)</b>	<b>0</b>	<b>(123,092)</b>	<b>45</b>								

**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
John R. Snyder	50	N/A		Snyder Properties	Rushville, IL	Lessor
Vaughn I. Snyder	50					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	30 Depreciation	\$	Snyder Properties	100.00%	\$ 31,912	\$ 31,912	1
2	V	32 Interest		Snyder Properties	100.00%	31,095	31,095	2
3	V	34 Rent	90,000	Snyder Properties	100.00%		(90,000)	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		\$ 90,000			\$ 63,007	\$ * (26,993)	14

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

Facility Name &amp; ID Number

Snyders-Vaughn Haven

#

0005363

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	John R. Snyder	Administrator	Administrator	50.00	N/A	50	100.00	Salary	\$ 5,200	17(1)	1
2	Marcia Dianne Snyder	DON	Nursing Admin.	0.00	N/A	50	100.00	Salary	3,600	10(1)	2
3	Vaughn Snyder	Owner	Officer	50.00	N/A	2	5.00	Salary	2,000	17(1)	3
4	Aaron Snyder	Clerical	Clerical	0.00	N/A	26	65.00	Salary	9,716	21(1)	4
5	Edna L. Busen	Clerical	Clerical	0.00	N/A	4	10.00	Salary	1,456	21(1)	5
6	Gregg Snyder	Clerical	Clerical	0.00	N/A	2	5.00	Salary	800	21(1)	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,772		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven

# 0005363 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		N/A							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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Snyders-Vaughn Haven

# 0005363

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		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Chrysler Credit		X	Vehicle purchase	\$614.00	12/22/04	\$ 30,744	\$ 9,738	01/16/10	0.0769	\$ 827	1						
2	First Bank		X	Mortgage	\$13,445.00	11/01/95	1,133,854	532,718	11/07/15	0.0894	31,095	2						
3	Schuyler State Bank		X	Vehicle purchase	\$696.00	03/16/05	42,127	14,803	03/16/10	0.0590	1,373	3						
4												4						
5												5						
	<b>Working Capital</b>																	
6	Schuyler State Bank		X	Line of Credit	Varies	09/30/05	125,000	300,000	09/30/08	0.0850	27,214	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$14,755.00		\$ 1,331,725	\$ 857,259			\$ 60,509	9						
	<b>B. Non-Facility Related*</b>																	
10	Margin Interest Cost										25,178	10						
11									Interest income offset		(167)	11						
12									Nonallowable Margin Interest		(25,178)	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (167)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,331,725	\$ 857,259			\$ 60,342	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

**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 2007 report.			\$	<b>30,000</b>	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.)		2007	\$	<b>37,515</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>7,515</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>30,000</b>	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b> Non-Care			\$	<b>(89)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>37,426</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2003	<u>29,416</u>	8	<b>FOR BHF USE ONLY</b>	
	2004	<u>32,639</u>	9	13	FROM R. E. TAX STATEMENT FOR 2007 \$
	2005	<u>34,071</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2006	<u>36,588</u>	11	15	LESS REFUND FROM LINE 6 \$
	2007	<u>37,515</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>Accrual - same a last year</b>					

**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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**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 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 Snyders-Vaughn Haven COUNTY Schuyler

FACILITY IDPH LICENSE NUMBER 0005363

CONTACT PERSON REGARDING THIS REPORT John R. Snyder

TELEPHONE 217-322-3201 FAX #: 217-322-6537

**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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-170-014-00</u>	<u>Nursing Home</u>	\$ <u>1,580.96</u>	\$ <u>1,580.96</u>
2. <u>12-131-009-00</u>	<u>Nursing Home</u>	\$ <u>209.12</u>	\$ <u>209.12</u>
3. <u>12-131-003-00</u>	<u>Nursing Home</u>	\$ <u>171.06</u>	\$ <u>171.06</u>
4. <u>12-126-006-00</u>	<u>Nursing Home</u>	\$ <u>282.50</u>	\$ <u>282.50</u>
5. <u>12-126-005-00</u>	<u>Nursing Home</u>	\$ <u>68.26</u>	\$ <u>68.26</u>
6. <u>12-126-004-00</u>	<u>Nursing Home</u>	\$ <u>385.10</u>	\$ <u>385.10</u>
7. <u>12-126-003-00</u>	<u>Nursing Home</u>	\$ <u>33,950.20</u>	\$ <u>33,950.20</u>
8. <u>12-131-007-00</u>	<u>Nursing Home</u>	\$ <u>57.50</u>	\$ <u>57.50</u>
9. <u>12-125-001-00 &amp; 12-170-012-00</u>	<u>Nursing Home</u>	\$ <u>721.66</u>	\$ <u>721.66</u>
10. <u>12-130-014-00</u>	<u>Lot 28 James Beard Addit. (Ora Agan</u>	\$ <u>88.80</u>	\$ <u></u>
	<b>TOTALS</b>	\$ <u>37,515.16</u>	\$ <u>37,426.36</u>

**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? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven

# 0005363

Report Period Beginning:

01/01/08

Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 46,354 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

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).

N/A

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>215,000</u>	<u>1992</u>	<u>\$ 41,500</u>	<u>1</u>
2	<u>Resident Care</u>		<u>1997</u>	<u>31,500</u>	<u>2</u>
3	<b>TOTALS</b>	<b>215,000</b>		<b>\$ 73,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven# 0005363

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	99		1992		\$ 1,276,487	\$	40	\$ 31,912	\$ 31,912	\$ 514,743	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Prior Years				173,475		Various			173,475	9
10	Drop Ceiling		1993		1,046	70	15	70		1,111	10
11	Alarm System		1996		9,173		10			9,173	11
12	Boiler		1996		2,242		10			2,242	12
13	Landscaping		1997		3,684	368	10		(368)	3,864	13
14	Roof		1997		3,427	169	10	169		3,596	14
15	Carpet		1997		3,080	154	10	154		3,234	15
16	Door		1997		4,494	228	10	228		4,722	16
17	Boiler		1997		503	28	10	28		531	17
18	A/C - Compressor		1997		839	41	10	41		880	18
19	Boiler		1999		2,840	284	10	284		2,698	19
20	Air Conditioner		1999		3,500	350	10	350		3,325	20
21	Fire Alarm System		1999		55,739	5,574	10	5,574		52,953	21
22	Parking Lot		1999		55,214	5,521	10	5,521		52,558	22
23	Landscaping		2000		23,959	2,396	10	2,396		20,366	23
24	Fire Alarm System		2000		7,032	704	10	704		5,984	24
25	Concrete Sidewalks and Drive		2000		3,379	338	10	338		2,874	25
26	Landscaping		2000		1,079	108	10	108		918	26
27	Concrete Sidewalks and Drive		2000		535	54	10	54		459	27
28	Plumbing Improvements		2000		2,257	226	10	226		1,921	28
29	Wall Coverings		2000		2,870	286	10	286		2,431	29
30	Electrical Improvements		2000		1,243	124	10	124		1,054	30
31	Door Frame		2000		791	80	10	80		680	31
32	Water Softner		2001		6,543	654	10	654		4,905	32
33	Landscaping		2001		1,804	180	10	180		1,350	33
34	Roofing		2001		2,934	293	10	293		2,198	34
35	Door Locks		2002		2,783	278	10	278		1,807	35
36	Storage		2003		7,281	728	10	728		4,004	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Air Conditioners	2004	\$ 6,477	\$ 648	10	\$ 648		\$ 2,916	37
38	Air Conditioners	2004	16,031	1,604	10	1,604		7,218	38
39	Air Conditioner	2005	4,700	470	10	470		1,645	39
40	Fire Alarm System	2005	3,379	338	10	338		1,183	40
41	Boiler	2005	2,728	272	10	272		952	41
42	Sidewalks	2005	4,286	428	10	428		1,498	42
43	Gutters	2005	1,326	132	10	132		462	43
44	Landscaping	2005	2,003	200	10	200		700	44
45	Sidewalks	2005	4,497	450	10	450		1,575	45
46	Air Conditioners	2005	14,630	1,463	10	1,463		5,121	46
47	Gazebo	2005	12,974	1,298	10	1,298		4,543	47
48	Boiler	2006	2,703	270	10	270		675	48
49									49
50	Purchase & Installation of new hydraulic cylinder	2008	33,887		10	1,694	1,694	1,694	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,769,854	\$ 26,809		\$ 60,047	\$ 33,238	\$ 910,238	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 38,036	\$ 3,768	\$ 4,196	\$ 428	5-10	\$ 14,095	71
72	Current Year Purchases	3,249		325	325	5	325	72
73	Fully Depreciated Assets	745,387					745,387	73
74								74
75	TOTALS	\$ 786,672	\$ 3,768	\$ 4,521	\$ 753		\$ 759,807	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	See Schedule 13A	See Schedule 13A	See Sch 13A	\$ 30,300	\$ 508	\$ 508	\$	5	\$ 29,537	76
77	Resident Care	99 Chrysler van	2004	11,850	2,237	2,237		5	10,133	77
78	Resident Care	04 Ford Bus	2005	42,109	8,422	8,422		5	29,477	78
79	Maintenance	2005 Dodge Truck	2004	34,438	6,888	6,888		5	30,996	79
80	TOTALS			\$ 118,697	\$ 18,055	\$ 18,055	\$		\$ 100,143	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,748,223	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,632	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,623	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 33,991	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,770,188	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Snyder's Vaughn-Haven, Inc.

Provider #: 0005363

1/1/2008 to 12/31/2008

Schedule 13A

XI (D) - Vehicle Depreciation

Line 76

Use	Make & Model	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accum Depreciation
Maintenance	2005 Dodge Cab Upgrade	2005	2,541	508	508	0	5	1,778
Maintenance	1990 Dodge van	1991	8,633			-	5	8,633
Maintenance	1995 Dodge truck	1996	11,665			-	5	11,665
Administrative	1997 Plymouth Neon	1997	7,461			-	5	7,461
			<u>30,300</u>	<u>508</u>	<u>508</u>	<u>0</u>		<u>29,537</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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					N/A			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 \_\_\_\_\_.

N/A

N/A

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 7,434 Description: Dishwasher - \$2940; Copier - \$4494

(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			\$ <u>N/A</u>	\$	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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1,3)	1619 hrs	33,955	114	6,823		1,733	40,778	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				49,030		49,030	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 33,955	114	\$ 6,823	\$ 49,030	1,733	\$ 89,808	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Snyders-Vaughn Haven**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.**

# **0005363**  
 As of **12/31/08**

Report Period Beginning: **01/01/08**  
 (last day of reporting year)

Ending: **12/31/08**

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,394,964	\$ 1,394,964	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>-0-</u> )	1,231,877	1,231,877	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,924	21,924	6
7	Other Prepaid Expenses	8,516	8,516	7
8	Accounts Receivable (owners or related parties)	48,261	48,261	8
9	Other(specify): <b>Due to Related Party</b>	4,481	4,481	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,710,023	\$ 2,710,023	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		73,000	13
14	Buildings, at Historical Cost	443,977	1,769,854	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	913,186	905,369	16
17	Accumulated Depreciation (book methods)	(1,168,680)	(1,770,188)	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):			22
23	Other(specify): <b>Property Tax</b>	6,543	6,543	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 195,026	\$ 984,578	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,905,049	\$ 3,694,601	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,029,782	\$ 1,029,782	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,794	12,794	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,000	30,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation	87,460	87,460	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Payroll Liabilities</b>	51,517	51,517	36
37	<b>See Schedule 17A</b>	230,814	230,814	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,442,367	\$ 1,442,367	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	324,541	324,541	39
40	Mortgage Payable		532,718	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 324,541	\$ 857,259	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,766,908	\$ 2,299,626	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,138,141	\$ 1,394,975	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,905,049	\$ 3,694,601	48

Snyder's Vaughn-Haven, Inc.  
Provider # 0005363  
01/01/08 to 12/31/08

Schedule 17A

XV: Special Services	After	
	<u>Operating</u>	<u>Consolidation</u>
Line 37 - Other Current Liabilities		
V.I. Snyder Loan	132,407	132,407
J.R. Snyder Loan	97,798	97,798
Resident Refunds	609	609
	<u>230,814</u>	<u>230,814</u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,118,888</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>24,355</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,143,243</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(5,102)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(5,102)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,138,141</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 2,152,949	1
2	Discounts and Allowances for all Levels	103,610	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,256,559	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	37,492	6
7	Oxygen	400	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 37,892	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	46,913	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,181	19
20	Radiology and X-Ray		20
21	Other Medical Services	16,113	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 79,210	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	167	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 167	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vending Income</u>	880	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 880	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,374,708	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	662,246	31
32	Health Care	906,722	32
33	General Administration	392,202	33
	<b>B. Capital Expense</b>		
34	Ownership	238,736	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	119,900	35
36	Provider Participation Fee	60,004	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,379,810	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(5,102)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (5,102)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity is a cash basis taxpayer

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Snyders-Vaughn Haven

# 0005363

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	160	\$ 3,600	\$ 22.50	1
2	Assistant Director of Nursing				2
3	Registered Nurses	5,241	89,942	16.66	3
4	Licensed Practical Nurses	17,316	261,755	14.43	4
5	CNAs & Orderlies	44,552	408,044	8.77	5
6	CNA Trainees				6
7	Licensed Therapist	1,514	33,955	20.97	7
8	Rehab/Therapy Aides				8
9	Activity Director	1,107	10,037	8.32	9
10	Activity Assistants	2,011	18,076	8.64	10
11	Social Service Workers	1,911	24,329	12.24	11
12	Dietician				12
13	Food Service Supervisor	2,160	30,962	14.33	13
14	Head Cook				14
15	Cook Helpers/Assistants	17,880	145,603	7.85	15
16	Dishwashers				16
17	Maintenance Workers	2,076	18,242	8.04	17
18	Housekeepers	6,633	70,085	10.00	18
19	Laundry	4,503	45,230	9.66	19
20	Administrator	2,080	5,200	32.50	20
21	Assistant Administrator	2,160	29,608	13.71	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	3,700	29,034	7.59	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	115,004	\$ 1,223,702 *	\$ 10.38	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	\$		35
36	Medical Director	Monthly 1,400	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,556	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	105 3,880	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	105 \$ 6,836		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4	N/A																			
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven# 0005363Report Period Beginning: 01/01/08Ending: 12/31/08**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. IHCA - \$5465
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,848 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. \$ 60,004  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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? No 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3
- (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? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees