

		FOR BHF USE					

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2009
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)
 FOR LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2009)

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>37-1194111001</u></p> <p>Date of Initial License for Current Owners: <u>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 <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other </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 checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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-Jan-09</u> to <u>31-Dec-09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Keith Swartzentruber</u> (Title) <u>Executive Director</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # () </td> </tr> </table> <p align="right"> 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) _____ (Type or Print Name) <u>Keith Swartzentruber</u> (Title) <u>Executive Director</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Keith Swartzentruber</u> (Title) <u>Executive Director</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()							

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 1-Jan-09 Ending: 31-Dec-09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,325	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	105	TOTALS	105	38,325	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	976	360	3,909	5,245	8
9	SNF/PED					9
10	ICF	9,494	19,631		29,125	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,470	19,991	3,909	34,370	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.68%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1988

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1988 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 105 and days of care provided 3,909

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 31-Dec-09 Fiscal Year: 31-Dec-09

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

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1-Jan-09 Ending: 31-Dec-09

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
	A. General Services										
1	Dietary	332,128		35,391	367,519		367,519		367,519		1
2	Food Purchase		261,790		261,790		261,790	(65,746)	196,044		2
3	Housekeeping	196,581	23,773	1,104	221,458		221,458	(7,283)	214,175		3
4	Laundry	80,028	13,829	50	93,907		93,907		93,907		4
5	Heat and Other Utilities			170,410	170,410		170,410	(46,434)	123,976		5
6	Maintenance	149,132	39,556	28,919	217,607		217,607	(2,979)	214,628		6
7	Other (specify):*										7
8	TOTAL General Services	757,869	338,948	235,874	1,332,691		1,332,691	(122,442)	1,210,249		8
	B. Health Care and Programs										
9	Medical Director			200	200		200		200		9
10	Nursing and Medical Records	2,784,770	116,716	20,758	2,922,244		2,922,244	(18,591)	2,903,653		10
10a	Therapy	15,233	2,461	298,340	316,034		316,034		316,034		10a
11	Activities	129,013	10,233	808	140,054		140,054		140,054		11
12	Social Services	77,696	839	1,750	80,285		80,285	(1,525)	78,760		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,006,712	130,249	321,856	3,458,817		3,458,817	(20,116)	3,438,701		16
	C. General Administration										
17	Administrative	178,942			178,942		178,942		178,942		17
18	Directors Fees										18
19	Professional Services			33,115	33,115	(240)	32,875		32,875		19
20	Dues, Fees, Subscriptions & Promotions			60,880	60,880	14	60,894	(48,368)	12,526		20
21	Clerical & General Office Expenses	272,317	30,655	57,096	360,068	(200)	359,868	(283,703)	76,165		21
22	Employee Benefits & Payroll Taxes			1,072,822	1,072,822		1,072,822		1,072,822		22
23	Inservice Training & Education			1,319	1,319		1,319		1,319		23
24	Travel and Seminar			19,540	19,540	426	19,966		19,966		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			59,741	59,741		59,741		59,741		26
27	Other (specify):*										27
28	TOTAL General Administration	451,259	30,655	1,304,513	1,786,427		1,786,427	(332,071)	1,454,356		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,215,840	499,852	1,862,243	6,577,935		6,577,935	(474,629)	6,103,306		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			197,200	197,200		197,200	1,285	198,485			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,921	47,921		47,921	(5,038)	42,883			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,849	5,849		5,849		5,849			35
36	Other (specify):*											36
37	TOTAL Ownership			250,970	250,970		250,970	(3,753)	247,217			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		201,871	18,075	219,946		219,946		219,946			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		201,871	75,563	277,434		277,434		277,434			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,215,840	701,723	2,188,776	7,106,339		7,106,339	(478,382)	6,627,957			45

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1-Jan-09

Ending:

31-Dec-09

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	(44,449)	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	1,285	30.3		9
10	Interest and Other Investment Income	(5,038)	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	(430,180)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (478,382)		\$	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))	\$ (478,382)		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	Dental Care		x			44
45	Other-Attach Schedule Physician		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1-Jan-09 Ending: 31-Dec-09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 1-Jan-09 Ending:

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Snyder Village Health Center

0033647

Report Period Beginning:

1-Jan-09

Ending:

31-Dec-09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Commerce Bank		X	Building	\$12,758.00	1-Aug-87	\$ 3,450,000	\$ 776,699	Sep-26	5.071%	\$ 40,229.00	1								
2	CDAP Village Metamora		X	Building	\$4,340.00	Various	614,000	47,928	Various	3.750%	2,939.00	2								
3											-	3								
4											-	4								
5											-	5								
Working Capital																				
6	Gift Annuity		X	Building	\$510.00	Various	84,000	45,658	Various	6.750%	4,753.00	6								
7											-	7								
8							Less: Interest Income				(5,038.00)	8								
9	TOTAL Facility Related				\$17,608.00		\$ 4,148,000	\$ 870,285			\$ 42,883	9								
B. Non-Facility Related*																				
10											-	10								
11											-	11								
12											-	12								
13											-	13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 4,148,000	\$ 870,285			\$ 42,883	15								

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

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

(See instructions.)

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u> </u>	<u>1200 East Partridge</u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
	TOTALS	\$ <u> </u>	\$ <u> </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? YES x NO

If YES, attach an explanation and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1-Jan-09

Ending:

31-Dec-09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,870 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

[Snyder Village Retirement Community Apartments - 41 Apartments @ 38,793 Ft2](#)

[Snyder Village Retirement Community Cottages - 135 Cottages @ 300,000 Ft2](#)

[Snyder Village Assisted Living - 41 Apartments @ 21,000 Ft2](#)

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Snyder Village Health Center

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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		\$ 921,746	4
5			1992	1992	127,495	2,833	45	2,833		49,816	5
6			1992	1992	33,830	1,353	25	1,353		23,228	6
7	18		1994	1994	600,872	13,353	45	13,353		211,420	7
8	26		1994	1994	1,256,597	27,924	45	27,924		421,190	8
	Improvement Type**										
9		Fire Control System		1989	5,152	193	20	190	(3)	5,152	9
10		Century Tub		1989	7,694		10			7,694	10
11		Asphalt		1990	1,820	91	20	91		1,775	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		1,266	15
16		Door Locks		1992	1,200	60	20	60		1,065	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		19,263	19
20		Services Windows		1995	201,662	4,481	45	4,481		64,474	20
21		Landscaping		1995	13,848	692	20	692		8,208	21
22		Canopy		1995	1,102	55	20	55		775	22
23		Electrical Maintenance		1995	595	40	15	40		571	23
24		Door Locks		1995	505	34	15	34		488	24
25		Front Canopy		1996	44,945	999	45	999		12,470	25
26		Tower		1996	7,360	368	20	368		5,029	26
27		Door Open		1996	3,344		10			3,344	27
28		Landscaping		1997	1,500	75	20	75		938	28
29		Front Door Wiring		1997	1,396	70	20	70		897	29
30		Kelly Glass		1998	3,527	176	20	176		2,113	30
31		MTCO Phone System		1998	18,914	757	25	757		7,578	31
32		Carpet		1998	15,719		10			15,719	32
33		Heater		1999	1,784	45	10	48	3	1,784	33
34		Security Camera		1999	2,510	167	15	167		1,838	34
35		Motion Detector		1999	790		10			790	35
36		Shelving		1999	673		10	3	3	673	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:

1-Jan-09

Ending:

31-Dec-09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic Door Open	2000	\$ 5,449	\$	15	\$ 363	\$ 363	\$ 3,449	37
38	Blacktop	2000	21,736	1,087	20	1,087		9,873	38
39	Sunroom	2000	86,410	1,920	45	1,920		18,237	39
40	Generator	2000	36,206	1,810	20	1,810		17,121	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,714	571	10	571		5,520	42
43	Nursing Office Addition	2001	751,810	16,707	45	16,707		142,100	43
44	Sunroom	2001	11,315	1,132	10	1,132		10,188	44
45	Tower	2001	5,640	564	10	564		4,841	45
46	Door	2001	2,545	255	10	255		2,082	46
47	Carpet	2001	3,529	353	10	353		2,883	47
48	Nurse Office Addition	2001	4,943	247	20	247		2,161	48
49	Blacktop	2001	12,054	603	20	603		4,925	49
50	Roof	2002	36,779	2,452	15	2,452		18,595	50
51	Hall 2 Room Alert	2002	5,015		5			5,015	51
52	Door, Tile, Drapes, Wall	2003	4,557	570	8	570		3,896	52
53	Door	2004	1,640		3			1,640	53
54	Roam Alert	2004	4,488	224	5	222	(2)	4,488	54
55	Carpet Hall 2	2004	856	100	5	101	1	856	55
56	Draperies	2004	2,335	117	5	116	(1)	2,335	56
57	Heat Pump	2005	2,165	217	10	217		1,031	57
58	Water Heater	2005	4,240	424	10	424		1,943	58
59	Therapy room door	2005	755	151	5	151		642	59
60	Hall 1 Nurses Station	2005	9,010	451	20	451		1,916	60
61	Service Door	2005	950		3			950	61
62	Blacktop Sealcoat	2005	3,373	675	5	675		2,868	62
63	Disposal unit	2006	2,221	222	10	222		869	63
64	Heat pump	2006	4,981	498	10	498		1,868	64
65	Air conditioning unit	2006	1,183	129	5	237	108	849	65
66	Heat pump	2006	4,260	426	10	426		1,419	66
67	Hall carpeting	2006	29,587	2,959	10	2,959		9,615	67
68	Sidewalk	2006	900	45	20	45		165	68
69	Alarm system	2007	3,304	661	5	661		1,981	69
70	TOTAL (lines 4 thru 69)		\$ 5,397,347	\$ 133,555		\$ 134,027	\$ 472	\$ 2,094,011	70

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

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0033647

Report Period Beginning:

1-Jan-09

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,397,347	\$ 133,555		\$ 134,027	\$ 472	\$ 2,094,011	1
2	Heat pump	2007	9,181	918	10	918		2,752	2
3	Hall 2 flooring	2007	27,466	2,747	10	2,747		6,638	3
4	Front signage	2008	15,386	1,539	10	1,539		1,923	4
5	Blacktop	2008	15,488	774	20	774		901	5
6	Rm flooring, wall & window covering, wood work, windows	2009	40,354	504	20	503	(1)	503	6
7	Energy management system controls	2009	19,344	1,911	10	1,929	18	1,929	7
8	Plumbing & sprinkler system	2009	21,157	1,134	10	1,930	796	1,930	8
9	Thermo systems	2009	1,808	45	10	45		45	9
10	Fencing	2009	909	38	10	38		38	10
11	Courtyard landscaping	2009	2,539	63	10	63		63	11
12	Window blinds for dining room	2009	1,329	222	5	222		222	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,552,308	\$ 143,450		\$ 144,735	\$ 1,285	\$ 2,110,955	34

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

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Report Period Beginning:

1-Jan-09

Ending:

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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	\$ 239,799	\$ 41,821	\$ 41,821	\$	various	\$ 181,893	71
72	Current Year Purchases	153,335	11,929	11,929		various	11,929	72
73	Fully Depreciated Assets	742,824				various	742,824	73
74								74
75	TOTALS	\$ 1,135,958	\$ 53,750	\$ 53,750	\$		\$ 936,646	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				10	29,900	79
80	TOTALS			\$ 150,757	\$	\$	\$		\$ 150,757	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 6,883,323	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 197,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 198,485	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 1,285	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,198,358	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	\$ 105,631	92
93			93
94			94
95		\$ 105,631	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 5,849 Description: Postage Meter \$1,178; Copier \$4,671

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</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			
		1	2	3	4
		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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)	
TOTAL TRAINED	

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	421	\$ 31,700	\$	421	\$ 31,700	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		861	62,101		861	62,101	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		506	37,439		506	37,439	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				132,098		132,098	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					69,773		69,773	13
14	TOTAL			\$	1,788	\$ 131,240	\$ 201,871	1,788	\$ 333,111	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Snyder Village Health Center

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Report Period Beginning: 1-Jan-09

Ending: 31-Dec-09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-09 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 571,326	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (16,895))	1,170,322		3
4	Supply Inventory (priced at FIFO)	32,523		4
5	Short-Term Investments	281,870		5
6	Prepaid Insurance	138,708		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R Other</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,177,854	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,335		12
13	Land	44,300		13
14	Buildings, at Historical Cost	5,234,885		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,570,477		16
17	Accumulated Depreciation (book methods)	(3,099,166)		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):	574,249		22
23	Other(specify): <u>Construction in Progress</u>	105,631		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,431,711	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,609,565	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 351,742	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,864		30
31	Accrued Taxes Payable (excluding real estate taxes)	(15)		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>	146,512		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 727,103	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	870,285		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)	\$ 870,285	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,597,388	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,012,177	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,609,565	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,406,706	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,406,706	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	605,471	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)	\$ 605,471	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,012,177	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1-Jan-09

Ending:

31-Dec-09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,739,257	1
2	Discounts and Allowances for all Levels	(1,286,852)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,452,405	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	935,048	6
7	Oxygen	45,525	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 980,573	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	7,189	12
13	Barber and Beauty Care	4,511	13
14	Non-Patient Meals	44,449	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	306,540	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,286	20
21	Other Medical Services	154,354	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 541,329	23
D. Non-Operating Revenue			
24	Contributions	266,434	24
25	Interest and Other Investment Income***	122,659	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 389,093	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	297,609	28
28a	Other Income	50,801	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 348,410	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,711,810	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,332,691	31
32	Health Care	3,458,817	32
33	General Administration	1,786,427	33
B. Capital Expense			
34	Ownership	250,970	34
C. Ancillary Expense			
35	Special Cost Centers	219,946	35
36	Provider Participation Fee	57,488	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,106,339	40
41	Income before Income Taxes (line 30 minus line 40)**	605,471	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 605,471	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

01/01/09

Ending:

31-Dec-09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	2,080	\$ 73,328	\$ 35.25	1
2	Assistant Director of Nursing	1,699	1,863	54,997	29.52	2
3	Registered Nurses	23,763	25,617	531,595	20.75	3
4	Licensed Practical Nurses	19,898	21,678	542,360	25.02	4
5	CNAs & Orderlies	103,225	112,636	1,487,855	13.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	617	657	15,233	23.19	8
9	Activity Director	1,884	2,080	33,290	16.00	9
10	Activity Assistants	8,523	9,300	95,723	10.29	10
11	Social Service Workers	4,557	4,980	77,696	15.60	11
12	Dietician	1,636	2,006	35,579	17.74	12
13	Food Service Supervisor	1,701	1,867	29,043	15.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,695	26,256	267,505	10.19	15
16	Dishwashers					16
17	Maintenance Workers	10,095	10,890	149,132	13.69	17
18	Housekeepers	15,462	16,731	196,581	11.75	18
19	Laundry	6,982	7,538	80,028	10.62	19
20	Administrator	1,920	2,080	76,746	36.90	20
21	Assistant Administrator					21
22	Other Administrative	1,816	2,080	102,196	49.13	22
23	Office Manager	1,896	2,080	56,126	26.98	23
24	Clerical	9,457	10,446	138,215	13.23	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	3,932	4,272	55,220	12.93	31
32	Other Health Care(specify)					32
33	Other(specify)	900	1,049	39,415	37.57	33
34	TOTAL (lines 1 - 33)	246,538	268,186	\$ 4,137,863 *	\$ 15.43	34

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	215	\$ 9,240	1.3	35
36	Medical Director	2	200	9.3	36
37	Medical Records Consultant	29	2,117	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	10.3	39
40	Physical Therapy Consultant	58	3,690	10a.3	40
41	Occupational Therapy Consultant	68	4,348	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	35	2,224	10a.3	43
44	Activity Consultant	15	750	11.3	44
45	Social Service Consultant	25	1,227	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	459	\$ 24,696		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	84	\$ 3,081	10.3	50
51	Licensed Practical Nurses	400	12,509	10.3	51
52	Certified Nurse Assistants/Aides	4	70	10.3	52
53	TOTAL (lines 50 - 52)	488	\$ 15,660		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1-Jan-09

Ending:

31-Dec-09

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	
Tom Becker	Administrator		76,746	Workers' Compensation Insurance	\$ 262,405	IDPH License Fee	\$ 200	
Keith Swartzentruber	Executive Director		102,196	Unemployment Compensation Insurance	14,996	Advertising: Employee Recruitment	50,770	
				FICA Taxes	320,390	Health Care Worker Background Check	3,113	
				Employee Health Insurance	314,657	(Indicate # of checks performed <u>311.3</u>)		
				Employee Meals		Patient Background Checks	116	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of IL	3,860	
See Schedule				Employee Pension Plan	120,515	Central IL Quality Alliance	900	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Life/Disability	2,472	Dues & Licenses	871	
(List each licensed administrator separately.)			\$ 178,942	Employee Flex Time	15,134	Subscription	20	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$								
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$				\$ 1,072,822			\$ 12,526	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heinold Banwart LTD	Accounting		18,494				Out-of-State Travel	\$
Robert Rein CPA	Accounting		5,300					
FR&R	Consulting		60				In-State Travel	8,535
Davis & Campbell LLC	Legal		150					
Johnson, Bunce & Noble	Legal		836				Seminar Expense	11,431
Adaptasoft, Inc.	Computer		5,494					
Reclassification			240				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
Designware Systems, Inc.	Computer		2,541				TOTAL	\$ 19,966
See Schedule								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 33,115					

* Attach copy of IMRF notifications

**See instructions.

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	Amount of Expense Amortized Per Year								
					5 FY2006	6 FY2007	7 FY2008	8 FY2009	9 FY2010	10 FY2011	11 FY2012	12 FY2013	13 FY2014
1	Carpentry	May 2001	\$ 1,244		\$ 124	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
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19													
20	TOTALS		\$ 1,244		\$ 124	\$	\$	\$	\$	\$	\$	\$	\$

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 3,860
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,234 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 57,488
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes: OP therapy For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 44,449
- (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.
- (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.