



Facility Name & ID Number Snyders-Vaughn Haven

# 0005363 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	4,343	805	1,592	6,740	8
9	SNF/PED					9
10	ICF	10,793	3,953		14,746	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,136	4,758	1,592	21,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.46%

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 1,592

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Snyders-Vaughn Haven

# 0005363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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	192,076	20,331		212,407			212,407		1	
2	Food Purchase		118,903		118,903		(1,155)	117,748		2	
3	Housekeeping	63,588	6,152	1,323	71,063			71,063		3	
4	Laundry	45,787	14,989		60,776			60,776		4	
5	Heat and Other Utilities			94,950	94,950			94,950		5	
6	Maintenance	34,731	19,569	35,017	89,317			89,317		6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	336,182	179,944	131,290	647,416		(1,155)	646,261		8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,800	2,800			2,800		9	
10	Nursing and Medical Records	782,152	38,496	4,487	825,135			825,135		10	
10a	Therapy	38,597		14,844	53,441			53,441		10a	
11	Activities	18,537	329		18,866			18,866		11	
12	Social Services	5,804		3,840	9,644			9,644		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	845,090	38,825	25,971	909,886			909,886		16	
	<b>C. General Administration</b>										
17	Administrative	52,483			52,483			52,483		17	
18	Directors Fees									18	
19	Professional Services			31,249	31,249			31,249		19	
20	Dues, Fees, Subscriptions & Promotions			12,904	12,904		(1,839)	11,065		20	
21	Clerical & General Office Expenses	32,542	2,811	20,290	55,643		(33)	55,610		21	
22	Employee Benefits & Payroll Taxes			169,314	169,314			169,314		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			448	448			448		24	
25	Other Admin. Staff Transportation			119	119			119		25	
26	Insurance-Prop.Liab.Malpractice			45,727	45,727			45,727		26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	85,025	2,811	280,051	367,887		(1,872)	366,015		28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,266,297	221,580	437,312	1,925,189		(3,027)	1,922,162		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 & ID Number Snyders-Vaughn Haven

#0005363

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

12/31/2009

## 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			10,617	10,617	10,617	67,218	77,835				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,884	24,884	24,884	33,692	58,576				32
33	Real Estate Taxes			40,646	40,646	40,646	(2,052)	38,594				33
34	Rent-Facility & Grounds			110,000	110,000	110,000	(110,000)					34
35	Rent-Equipment & Vehicles			6,350	6,350	6,350		6,350				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			192,497	192,497	192,497	(11,142)	181,355				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,589		65,589	65,589		65,589				39
40	Barber and Beauty Shops			1,379	1,379	1,379		1,379				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,235	52,235	52,235		52,235				42
43	Other (specify):* <b>Non-allowable cost</b>			63,626	63,626	63,626	(63,626)					43
44	<b>TOTAL Special Cost Centers</b>		65,589	117,240	182,829	182,829	(63,626)	119,203				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,266,297	287,169	747,049	2,300,515	2,300,515	(77,795)	2,222,720				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: 01/01/2009

Ending: 12/31/2009

**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	(6)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,851)	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	35,306	30		9
10	Interest and Other Investment Income	(376)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,815)	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	(50)	43		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	(41,387)	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 See PG5A	(22,596)	Vari		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (33,775)		\$	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)	(44,020)	Vari	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (44,020)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (77,795)		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

SEE ACCOUNTANTS' COMPILATION REPORT

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ID# 0005363

Report Period Beginning: 01/01/2009

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Treatments	\$ (1,277)	43	1
2	Vending Income	(1,149)	32	2
3	Lab Services	(16,246)	43	3
4	Non-allowable Lobbying Dues	(1,639)	20	4
5	Offset Supplies Income	(33)	21	5
6	Disallow unreconciled real estate tax	(2,052)	33	6
7	Non-Allowable Dues	(200)	19	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>		(22,596)	49

SEE ACCOUNTANTS' COMPILATION REPORT

**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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 Depreciation	\$	Snyder Properties	100.00%	\$ 31,912	\$ 31,912	1
2	V	32 Interest		Snyder Properties	100.00%	34,068	34,068	2
3	V	34 Rent	110,000	Snyder Properties	100.00%		(110,000)	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		\$ 110,000			\$ 65,980	\$ * (44,020)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

**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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V			N/A				16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven # 0005363 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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	\$ 16,783	17(1)	1
2	Marcia Dianne Snyder	DON	Nursing Admin.	0.00	N/A	50	100.00	Salary	11,040	10(1)	2
3	Aaron Snyder	Clerical	Clerical	0.00	N/A	40	100.00	Salary	17,068	21(1)	3
4	Gregg Snyder	Maintenance	Maintenance	0.00	N/A	37	90.00	Salary	17,130	6(1)	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 62,021		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: 01/01/2009

Ending: 2/31/2009

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 & ID Number

Snyders-Vaughn Haven

# 0005363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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		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	\$ 6,257	01/16/10	0.0769	\$ 425						
2	First Bank		X	Mortgage	\$13,445.00	11/01/95	1,133,854	484,073	11/07/15	0.0894	33,643						
3	Schuyler State Bank		X	Vehicle purchase	\$696.00	03/16/05	42,127	9,511	03/16/10	0.0590	1,013						
4											4						
5											5						
<b>Working Capital</b>																	
6	Schuyler State Bank		X	Line of Credit	Varies	09/30/05	125,000	296,750	09/30/08	0.0850	23,665						
7											7						
8											8						
9	<b>TOTAL Facility Related</b>				\$14,755.00		\$ 1,331,725	\$ 796,591			\$ 58,746						
<b>B. Non-Facility Related*</b>																	
10											10						
11	Medicare Audit		X	Audit							206						
12	Offset Interest Income		X								(376)						
13											13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(170)						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,331,725	\$ 796,591			\$ 58,576						

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

1. Real Estate Tax accrual used on 2008 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.)	2008	\$	<b>40,046</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>10,046</b>	3
4. Real Estate Tax accrual used for 2009 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>	<b>Unreconciled Difference</b>		<b>600</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.) Non Care</b>		\$	<b>(1,452)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>38,594</b>	7

  

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	<b>32,639</b>	8
	2005	<b>34,071</b>	9
	2006	<b>36,588</b>	10
	2007	<b>37,515</b>	11
	2008	<b>37,426</b>	12
<b>Accrual - same a last year</b>			

  

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**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 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 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 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)
	<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 &amp; 12-040-013-00</u>	<u>Nursing Home</u>	\$ <u>1,897.78</u>	\$ <u>1,897.78</u>
2.	<u>12-131-009-00</u>	<u>Nursing Home</u>	\$ <u>214.08</u>	\$ <u>214.08</u>
3.	<u>12-131-003-00</u>	<u>Nursing Home</u>	\$ <u>175.12</u>	\$ <u>175.12</u>

4.	<u>12-126-006-00</u>	<u>Nursing Home</u>	\$ <u>289.26</u>	\$ <u>289.26</u>
5.	<u>12-126-005-00</u>	<u>Nursing Home</u>	\$ <u>69.88</u>	\$ <u>69.88</u>
6.	<u>12-126-004-00</u>	<u>Nursing Home</u>	\$ <u>394.22</u>	\$ <u>394.22</u>
7.	<u>12-126-003-00</u>	<u>Nursing Home</u>	\$ <u>34,755.60</u>	\$ <u>34,755.60</u>
8.	<u>12-131-007-00</u>	<u>Nursing Home</u>	\$ <u>58.82</u>	\$ <u>58.82</u>
9.	<u>12-125-001-00 &amp; 12-170-012-00</u>	<u>Nursing Home</u>	\$ <u>738.78</u>	\$ <u>738.78</u>
10.	<u>12-130-014-00</u>	<u>\LOTS'&amp;3BLK23~ WILLIAM MC C</u>	\$ <u>1,452.16</u>	\$ <u></u>
<b>TOTALS</b>			\$ <u>40,045.70</u>	\$ <u>38,593.54</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 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven

# 0005363 Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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

**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	\$ 546,655	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		15	(65)	(65)	1,046	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		10	(180)	(180)	3,684	13
14		Roof	1997		3,427		10	(169)	(169)	3,427	14
15		Carpet	1997		3,080		10	(154)	(154)	3,080	15
16		Door	1997		4,494		10	(228)	(228)	4,494	16
17		Boiler	1997		503		10	(28)	(28)	503	17
18		A/C - Compressor	1997		839		10			839	18
19		Boiler	1999		2,840		10	142	142	2,840	19
20		Air Conditioner	1999		3,500		10	175	175	3,500	20
21		Fire Alarm System	1999		55,739		10	2,786	2,786	55,739	21
22		Parking Lot	1999		55,214		10	2,656	2,656	55,214	22
23		Landscaping	2000		23,959		10	2,396	2,396	20,366	23
24		Fire Alarm System	2000		7,032		10	704	704	6,688	24
25		Concrete Sidewalks and Drive	2000		3,379		10	338	338	3,212	25
26		Landscaping	2000		1,079		10	108	108	126	26
27		Concrete Sidewalks and Drive	2000		535		10	54	54	513	27
28		Plumbing Improvements	2000		2,257		10	226	226	2,147	28
29		Wall Coverings	2000		2,870		10	286	286	2,717	29
30		Electrical Improvements	2000		1,243		10	124	124	1,178	30
31		Door Frame	2000		791		10	80	80	760	31
32		Water Softner	2001		6,543		10	654	654	5,559	32
33		Landscaping	2001		1,804		10	180	180	1,530	33
34		Roofing	2001		2,934		10	293	293	2,491	34
35		Door Locks	2002		2,783		10	278	278	2,085	35
36		Storage	2003		7,281		10	728	728	4,732	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	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		\$	\$		\$	\$	\$	37
38								38
39	<u>2004</u>	<u>6,477</u>		<u>10</u>	<u>648</u>	<u>648</u>	<u>3,564</u>	39
40	<u>2004</u>	<u>16,031</u>		<u>10</u>	<u>1,604</u>	<u>1,604</u>	<u>8,822</u>	40
41	<u>2005</u>	<u>4,700</u>		<u>10</u>	<u>470</u>	<u>470</u>	<u>2,115</u>	41
42	<u>2005</u>	<u>3,379</u>		<u>10</u>	<u>338</u>	<u>338</u>	<u>1,521</u>	42
43	<u>2005</u>	<u>2,728</u>		<u>10</u>	<u>272</u>	<u>272</u>	<u>1,224</u>	43
44	<u>2005</u>	<u>4,286</u>		<u>10</u>	<u>428</u>	<u>428</u>	<u>1,926</u>	44
45	<u>2005</u>	<u>1,326</u>		<u>10</u>	<u>132</u>	<u>132</u>	<u>594</u>	45
46	<u>2005</u>	<u>2,003</u>		<u>10</u>	<u>200</u>	<u>200</u>	<u>900</u>	46
47	<u>2005</u>	<u>4,497</u>		<u>10</u>	<u>450</u>	<u>450</u>	<u>2,025</u>	47
48	<u>2005</u>	<u>14,630</u>		<u>10</u>	<u>1,463</u>	<u>1,463</u>	<u>6,584</u>	48
49	<u>2005</u>	<u>12,974</u>		<u>10</u>	<u>1,298</u>	<u>1,298</u>	<u>5,841</u>	49
50	<u>2006</u>	<u>2,703</u>	<u>98</u>	<u>10</u>	<u>270</u>	<u>172</u>	<u>945</u>	50
51								51
52	<u>2008</u>	<u>33,887</u>		<u>10</u>	<u>3,389</u>	<u>3,389</u>	<u>5,083</u>	52
53								53
54								54
55	<u>2009</u>	<u>6,526</u>	<u>70</u>	<u>10</u>	<u>326</u>	<u>256</u>	<u>326</u>	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	<b>TOTAL (lines 4 thru 69)</b>	<b>\$ 1,776,380</b>	<b>\$ 168</b>		<b>\$ 54,584</b>	<b>\$ 54,416</b>	<b>\$ 961,485</b>	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	\$ 41,285	\$ 8,552	\$ 4,846	\$ (3,706)	5-10	\$ 19,266	71
72	Current Year Purchases	3,499	1,897	350	(1,547)	5	350	72
73	Fully Depreciated Assets	745,387					745,387	73
74								74
75	TOTALS	\$ 790,171	\$ 10,449	\$ 5,196	\$ (5,253)		\$ 765,003	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	\$ 30,045	76
77	Resident Care	99 Chrysler van	2004	11,850		2,237	2,237	5	12,370	77
78	Resident Care	04 Ford Bus	2005	42,109		8,422	8,422	5	37,899	78
79	Maintenance	2005 Dodge Truck	2004	34,438		6,888	6,888	5	37,884	79
80	TOTALS			\$ 118,697	\$	\$ 18,055	\$ 18,055		\$ 118,198	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)	\$ 2,758,248	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,617	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,835	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,218	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,844,686	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			N/A		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  
 1/1/2009 to 12/31/2009

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	0	5	2,286
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>0</u>		<u>30,045</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

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

13. \_\_\_\_\_/2011 \$ \_\_\_\_\_

14. \_\_\_\_\_/2012 \$ \_\_\_\_\_

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: \$ 6,350 Description: Copier - \$4595; Dishwasher - \$1755

(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

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	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)	
<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	1 Schedule V Line & Column Reference	2 Staff		4 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		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1,3)	1736 hrs	38,597	247	14,844		1,983	53,441	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 prescrpts				65,589		65,589	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	TOTAL			\$ 38,597	247	\$ 14,844	\$ 65,589	1,983	\$ 119,030	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**# **0005363**Report Period Beginning: **01/01/2009**

Ending:

**12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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	\$ 438,030	\$ 438,030	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,216,138	1,216,138	3
4	Supply Inventory (priced at )			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>	3,068	3,068	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,735,937	\$ 1,735,937	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			14
15	Leasehold Improvements, at Historical Cost	449,505	1,776,380	15
16	Equipment, at Historical Cost	915,295	908,868	16
17	Accumulated Depreciation (book methods)	(1,189,914)	(1,844,686)	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 (sum of lines 11 thru 23)</b>	\$ 181,429	\$ 920,105	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,917,366	\$ 2,656,042	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 969,214	\$ 969,214	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,392	19,392	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	88,953	88,953	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Payroll Liabilities</b>	58,316	58,316	36
37	<b>See Schedule 17</b>	175,814	175,814	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,341,689	\$ 1,341,689	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	312,518	312,518	39
40	Mortgage Payable		484,073	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 (sum of lines 39 thru 44)</b>	\$ 312,518	\$ 796,591	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,654,207	\$ 2,138,280	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 263,159	\$ 517,762	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,917,366	\$ 2,656,042	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

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

Schedule 17A

<b>XV: Special Services</b>	<b>Operating</b>	<b>After Consolidation</b>
Line 37- Other Current Liabilities		
V.I Snyder Loan	132,407	132,407
J.R. Snyder Loan	42,798	42,798
Resident Refunds	609	609
	<u>175,814</u>	<u>175,814</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,138,141</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Prior Period Adjustment</b>	<b>(1,155,841)</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>(17,700)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>280,859</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>280,859</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>263,159</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	\$ 2,322,470	1
2	Discounts and Allowances for all Levels	105,203	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,427,673</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,267	6
7	Oxygen	128	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 52,395</b>	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	6	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,014	19
20	Radiology and X-Ray	165	20
21	Other Medical Services	18,458	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 99,748</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	376	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 376</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Income</b>	1,182	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,182</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,581,374</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	647,416	31
32	Health Care	909,886	32
33	General Administration	367,887	33
<b>B. Capital Expense</b>			
34	Ownership	192,497	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	130,594	35
36	Provider Participation Fee	52,235	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,300,515</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>280,859</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 280,859</b>	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.

\*\*\* 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.

The taxpayer files on a cash basis for income tax purposes



Facility Name & ID Number **Snyders-Vaughn Haven**

# **0005363**

Report Period Beginning:

**01/01/2009**

Ending:

**12/31/2009**

**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	530	530	\$ 11,918	\$ 22.49	1
2	Assistant Director of Nursing	1,902	2,006	43,509	21.69	2
3	Registered Nurses	1,902	1,916	36,797	19.21	3
4	Licensed Practical Nurses	16,143	16,866	257,724	15.28	4
5	CNAs & Orderlies	41,656	43,815	432,204	9.86	5
6	CNA Trainees					6
7	Licensed Therapist	1,626	1,736	38,597	22.23	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,986	2,031	18,537	9.13	10
11	Social Service Workers	428	486	5,804	11.94	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,220	15.01	13
14	Head Cook	8,014	8,425	72,774	8.64	14
15	Cook Helpers/Assistants	7,977	8,142	67,581	8.30	15
16	Dishwashers	2,450	2,522	20,501	8.13	16
17	Maintenance Workers	3,765	3,910	34,731	8.88	17
18	Housekeepers	7,178	7,643	63,588	8.32	18
19	Laundry	5,258	5,526	45,787	8.29	19
20	Administrator	516	516	16,783	32.53	20
21	Assistant Administrator	2,080	2,080	35,700	17.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,630	3,732	32,542	8.72	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)	109,121	113,962	\$ 1,266,297 *	\$ 11.11	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	80	2,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	2,974	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	96	3,840	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	296	\$ 9,614		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

Facility Name & ID Number **Snyders-Vaughn Haven**

# **0005363**

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

**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	
John Snyder	Administrator	50	\$ 16,783	Workers' Compensation Insurance	\$ 61,247	IDPH License Fee	\$ 1,990	
David Grate	Asst. Administrator	0	35,700	Unemployment Compensation Insurance	9,758	Advertising: Employee Recruitment	2,199	
				FICA Taxes	95,900	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed <u>58</u> )	580	
				Employee Meals		Patient Background Checks	17	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Association	5,465	
				Other Emp Relations & Benefits	2,409	Miscellaneous Liscenses & Fees	601	
						Miscellaneous Dues	1,899	
TOTAL (agree to Schedule V, line 17, col. 1)						Less Non-Allowable Dues	(200)	
(List each licensed administrator separately.)			\$ 52,483					
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(1,639)	
N/A							Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)			\$ 169,314	
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 11,065	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners	Unemployment Services		\$ 1,056	N/A			Out-of-State Travel	\$
Elavator Safety Services	Inspect Elevator		160					
Legat Arthitects	Life Safety Code		3,940				In-State Travel	
Computer Masters	Computer		2,271					
RSM McGladrey	Accounting		17,344				Seminar Expense	448
Schuyler Cty Clerk	Claim Filing		60					
Duane Morris	Legal		4,626				Entertainment Expense	( )
Wisconson Phy Services	Data Processing		18					
Vision Share Inc.	Data Processing		799					
Simple LTC	Data Processing		975					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 31,249				\$ 448	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
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15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyders-Vaughn Haven# 0005363Report Period Beginning: 01/01/2009Ending: 12/31/2009**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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,555 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 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. \$ 52,235  
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? 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. \$ 6
- (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
- (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.

**SEE ACCOUNTANTS' COMPILATION REPORT**