

Facility Name & ID Number Snyder Village

0033647 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	104	Skilled (SNF)	104	37,960	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	104	TOTALS	104	37,960	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	9,591	18,477	5,418	33,486	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,591	18,477	5,418	33,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.21%

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)

Out-patient Therapy

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 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 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 104 and days of care provided 4,446

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: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	426,439	21,531	13,239	461,209		461,209	(31,620)	429,589		1
2	Food Purchase		354,219		354,219		354,219	(85,801)	268,418		2
3	Housekeeping	209,456	34,170	404	244,030		244,030		244,030		3
4	Laundry	55,827	14,428		70,255		70,255		70,255		4
5	Heat and Other Utilities			140,111	140,111		140,111		140,111		5
6	Maintenance	165,102	40,639	31,112	236,853		236,853	(26,544)	210,309		6
7	Other (specify):* Waste Removal			833	833		833		833		7
8	TOTAL General Services	856,824	464,987	185,699	1,507,510		1,507,510	(143,965)	1,363,545		8
	B. Health Care and Programs										
9	Medical Director			250	250		250		250		9
10	Nursing and Medical Records	2,741,923	216,694	217,948	3,176,565		3,176,565	(18,900)	3,157,665		10
10a	Therapy	30,467	4,408	578,679	613,554		613,554	(4,704)	608,850		10a
11	Activities	157,606	9,976	3,357	170,939		170,939	1,944	172,883		11
12	Social Services	90,870	207	1,367	92,444		92,444		92,444		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,020,866	231,285	801,601	4,053,752		4,053,752	(21,660)	4,032,092		16
	C. General Administration										
17	Administrative	219,618			219,618		219,618	(60,788)	158,830		17
18	Directors Fees										18
19	Professional Services			146,073	146,073		146,073		146,073		19
20	Dues, Fees, Subscriptions & Promotions			27,578	27,578		27,578		27,578		20
21	Clerical & General Office Expenses	301,867	39,174	33,690	374,731		374,731	(139,345)	235,386		21
22	Employee Benefits & Payroll Taxes			881,081	881,081		881,081		881,081		22
23	Inservice Training & Education			990	990		990		990		23
24	Travel and Seminar			10,351	10,351		10,351	(943)	9,408		24
25	Other Admin. Staff Transportation			2,703	2,703		2,703		2,703		25
26	Insurance-Prop.Liab.Malpractice			100,746	100,746		100,746		100,746		26
27	Other (specify):*										27
28	TOTAL General Administration	521,485	39,174	1,203,212	1,763,871		1,763,871	(201,076)	1,562,795		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,399,175	735,446	2,190,512	7,325,133		7,325,133	(366,701)	6,958,432		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 Snyder Village

#0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

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			321,746	321,746	321,746	(3,667)	318,079				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,066	18,066	18,066	(692)	17,374				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,114	6,114	6,114		6,114				35
36	Other (specify):*											36
37	TOTAL Ownership			345,926	345,926	345,926	(4,359)	341,567				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		220,032	28,838	248,870	248,870		248,870				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,812	228,812	228,812		228,812				42
43	Other (specify):* Disallowed Costs	120,654		57,980	178,634	178,634	(178,634)					43
44	TOTAL Special Cost Centers	120,654	220,032	315,630	656,316	656,316	(178,634)	477,682				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,519,829	955,478	2,852,068	8,327,375	8,327,375	(549,694)	7,777,681				45

*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

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	(85,801)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,131)	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	(3,667)	30		9
10	Interest and Other Investment Income	(692)	32		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	(57)	43		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	7,496	43		24
25	Fund Raising, Advertising and Promotional	(183,902)	43		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 Page 5A	(276,940)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (549,694)		\$	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))	\$ (549,694)		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	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Snyder Village

ID# 0033647

Report Period Beginning: 1/1/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Service Fee income - Administrative	\$ (30,394)	17	1
2	Offset Service Fee income - Administrative	(51,526)	21	2
3	Offset Service Fee income - Administrative	64,100	43	3
4	Offset Service Fee income - Marketing/fundraising	(11,640)	43	4
5	Offset Service Fee income/exp - Activities/Trans	1,944	11	5
6	Offset Service Fee income - Dietary	(31,620)	1	6
7	Offset Service Fee income - Maintenance	(26,544)	6	7
8	Offset Service Fee income - Therapy	(4,704)	10a	8
9	Offset Service Fee income - Nursing	(18,900)	10	9
10	Offset Service Fee income - Administrative	(30,394)	17	10
11	Offset Service Fee income - Administrative	(86,526)	21	11
12	Offset Service Fee income - Administrative	(48,500)	43	12
13	Offset Misc. Other Revenue	(1,293)	21	13
14	Marketing/Development Travel & Seminar Exp	(943)	24	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	Total		(276,940)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Snyder Village# 0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(31,620)	0	0	0	0	0	0	0	0	0	0	(31,620)	1
2	Food Purchase	(85,801)	0	0	0	0	0	0	0	0	0	0	(85,801)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(26,544)	0	0	0	0	0	0	0	0	0	0	(26,544)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(143,965)	0	(143,965)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(18,900)	0	0	0	0	0	0	0	0	0	0	(18,900)	10
10a	Therapy	(4,704)	0	0	0	0	0	0	0	0	0	0	(4,704)	10a
11	Activities	1,944	0	0	0	0	0	0	0	0	0	0	1,944	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(21,660)	0	(21,660)	16									
	C. General Administration													
17	Administrative	(60,788)	0	0	0	0	0	0	0	0	0	0	(60,788)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(139,345)	0	0	0	0	0	0	0	0	0	0	(139,345)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(943)	0	0	0	0	0	0	0	0	0	0	(943)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(201,076)	0	(201,076)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(366,701)	0	(366,701)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,667)	0	0	0	0	0	0	0	0	0	0	(3,667)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(692)	0	0	0	0	0	0	0	0	0	0	(692)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,359)	0	0	0	0	0	0	0	0	0	0	(4,359)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(178,634)	0	0	0	0	0	0	0	0	0	0	(178,634)	43
44	TOTAL Special Cost Centers	(178,634)	0	0	0	0	0	0	0	0	0	0	(178,634)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(549,694)	0	0	0	0	0	0	0	0	0	0	(549,694)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supp						

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors:							1
2								2
3	Lois Lampe							3
4	Judy Winkler - President							4
5	Cheryl Harper - Secretary							5
6	Tammy Waterworth - Vice President							6
7	Greg Minger							7
8	Bill Christ							8
9	Kevin Brinkman							9
10	Diane Gravlin							10
11	Tom Brock - Treasurer							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

SEE ACCOUNTANTS' COMPILATION REPORT

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	N/A								\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Commerce Bank		X	Building	\$5,270.00	8/1/87	\$ 3,450,000	\$ 229,717	9/1/26	0.0167	\$ 4,370	1						
2	CDAP Village Metamora		X	Building	\$4,340.00	Various	614,000		Various	0.0375	178	2						
3	Goodfield State Bank		X	Building	\$1,700.00	12/1/12	300,000	265,492	12/1/27	0.0325	8,953	3						
4												4						
5												5						
Working Capital																		
6	Gift Annuity		X	Building	\$510.00	Various	84,000	36,533	Various	0.0675	4,565	6						
7												7						
8												8						
9	TOTAL Facility Related				\$11,820.00		\$ 4,448,000	\$ 531,742			\$ 18,066	9						
B. Non-Facility Related*																		
10											(692)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(692)	14						
15	TOTALS (line 9+line14)						\$ 4,448,000	\$ 531,742			\$ 17,374	15						

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2014 report.		\$	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	3
4.	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2010	<u>N/A</u>	8
		2011	<u>N/A</u>	9
		2012	<u>N/A</u>	10
		2013	<u>N/A</u>	11
		2014	<u>N/A</u>	12
This facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for the real estate tax is required.				
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2014 \$	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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyder Village 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 2014 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 2014.

	(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.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		TOTALS	\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

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 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

0033647 Report Period Beginning:

1/1/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,870 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories 1

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 - 168 Cottages @ approximately 315,000 Ft²

Snyder Village Assisted Living - 65 units @ approximately 37,000 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: N/A 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	\$ 1,178,978	4
5			1992	1992	127,495	2,833	45	2,833		66,814	5
6			1992	1992	33,830	1,353	25	1,353		31,346	6
7	18		1994	1994	600,872	13,353	45	13,353		291,538	7
8	26		1994	1994	1,256,597	27,924	45	27,924		588,734	8
	Improvement Type**										
9		Fire Control System		1989	5,152		20			5,152	9
10		Century Tub		1989	7,694		10			7,694	10
11		Asphalt		1990	1,820		20			1,820	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		20			1,400	15
16		Door Locks		1992	1,200		20			1,200	16
17		Patio		1992	1,219		10			1,219	17
18		Entrance Light		1993	619		10			619	18
19		Land Improvement		1994	25,546		20			25,546	19
20		Services Windows		1995	201,662	4,481	45	4,481		91,360	20
21		Landscaping		1995	13,848		20	692	692	12,360	21
22		Canopy		1995	1,102	50	20	52	2	1,102	22
23		Electrical Maintenance		1995	595		15			595	23
24		Door Locks		1995	505		15			505	24
25		Front Canopy		1996	44,945	999	45	999		18,464	25
26		Tower		1996	7,360	368	20	368		7,237	26
27		Door Open		1996	3,344		10			3,344	27
28		Landscaping		1997	1,500	75	20	75		1,388	28
29		Front Door Wiring		1997	1,396	70	20	70		1,317	29
30		Kelly Glass		1998	3,527	176	20	176		3,169	30
31		MTCO Phone System		1998	18,914	757	25	757		12,120	31
32		Carpet		1998	15,719		10			15,719	32
33		Heater		1999	1,784		10			1,784	33
34		Security Camera		1999	2,510		15			2,510	34
35		Motion Detector		1999	790		10			790	35
36		Shelving		1999	673		10			673	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

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 185	\$ 185	\$ 5,449	37
38	Blacktop	2000	21,736	1,087	20	1,087		16,395	38
39	Sunroom	2000	86,410	1,920	45	1,920		29,757	39
40	Generator	2000	36,206	1,810	20	1,810		27,981	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,714		10			5,714	42
43	Nursing Office Addition	2001	751,810	16,707	45	16,707		242,342	43
44	Sunroom	2001	11,315		10			11,315	44
45	Tower	2001	5,640		10			5,640	45
46	Door	2001	2,545		10			2,545	46
47	Carpet	2001	3,529		10			3,529	47
48	Nurse Office Addition	2001	4,943	247	20	247		3,643	48
49	Blacktop	2001	12,054	603	20	603		8,543	49
50	Roof	2002	36,779	2,452	15	2,452		33,307	50
51	Hall 2 Room Alert	2002	5,015		5			5,015	51
52	Door, Tile, Drapes, Wall	2003	4,557		8			4,557	52
53	Door	2004	1,640		3			1,640	53
54	Roam Alert	2004	4,488		5			4,488	54
55	Carpet Hall 2	2004	856		5			856	55
56	Drapery	2004	2,335		5			2,335	56
57	Heat Pump	2005	1,051		10			1,051	57
58	Water Heater	2005	4,240	177	10	177		4,240	58
59	Therapy room door	2005	755		5			755	59
60	Hall 1 Nurses Station	2005	9,010	451	20	451		4,622	60
61	Service Door	2005	950		3			950	61
62	Blacktop Sealcoat	2005	3,373		5			3,373	62
63	Disposal unit	2006		222	10		(222)		63
64	Heat pump	2006	4,981	498	10	498		4,856	64
65	Air conditioning unit	2006			5				65
66	Heat pump	2006	4,260	426	10	426		3,975	66
67	Hall carpeting	2006	21,377	2,959	10		(2,959)	21,377	67
68	Sidewalk	2006		45	20		(45)		68
69	Alarm system	2007	3,304		5			3,304	69
70	TOTAL (lines 4 thru 69)		\$ 5,383,719	\$ 124,915		\$ 122,568	\$ (2,347)	\$ 2,854,599	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,383,719	\$ 124,915		\$ 122,568	\$ (2,347)	\$ 2,854,599	1
2	Heat pump	2007	9,181	918	10	918		8,260	2
3	Hall 2 flooring	2007		2,747	10		(2,747)		3
4	Front signage	2008	15,386	1,539	10	1,539		11,157	4
5	Blacktop	2008	15,488	774	20	774		5,545	5
6	Heat Pump	2008	10,609	1,061	10	1,061		7,957	6
7	Rm flooring, wall & window covering, wood work, windows	2009	40,354	2,018	20	2,018		12,611	7
8	Energy management system controls	2009	19,344	1,934	10	1,934		13,533	8
9	Plumbing & sprinkler system	2009	21,157	1,937	10	1,937		14,298	9
10	Thermo systems	2009		181	10		(181)		10
11	Fencing	2009		91	10		(91)		11
12	Courtyard landscaping	2009	2,539	254	10	254		1,587	12
13	Window blinds for dining room	2009			5				13
14	Cable TV wiring	2009	33,168	4,146	8	4,146		25,558	14
15	Heat Pump	2010	16,061	1,606	10	1,606		8,699	15
16	Motion Detector & Electrical Fixtures	2010	9,081	908	10	908		4,995	16
17	Blacktop	2010	27,905	1,395	20	1,395		7,675	17
18	Schrepfer front door	2010	3,766	377	10	377		1,979	18
19	Fire system	2010		101	5		(101)		19
20	Heat Pump halls 1, 2, 3	2011	10,345	1,035	10	1,035		5,087	20
21	Health Center Hall I Room Design/Drawings/Engineering	2011	13,665	1,367	10	1,367		6,718	21
22	Wall mounted shadow box & bulletin board	2011	2,528	253	10	253		1,243	22
23	Light fixtures, switches, outlets, breakers, wiring	2011	36,050	1,442	25	1,442		7,088	23
24	Toilets, sinks, faucets, piping, grab bar, lav top	2011	9,847	393	25	393		1,932	24
25	Corner & medicine cabinet, headboards	2011	9,053	905	10	905		4,448	25
26	Wall studs, wall board, paint, trim & guards	2011	6,120	245	25	245		1,204	26
27	Curtains w/track	2011	3,386	339	10	339		1,666	27
28	Chair rail & oak light boxes	2011	6,234	249	25	249		1,224	28
29	Window blinds & valances	2011	8,247	330	25	330		1,622	29
30	Wall protection 4'x8' sheets for resident rooms	2011	26,660	1,066	25	1,066		4,819	30
31	Health Center Hall I Dining Rm Design/Drawings/Engineering	2011	124,070	2,757	45	2,757		12,463	31
32	Dining room flooring	2011	20,000	800	25	800		3,616	32
33	Hall 1 & 13 resident room flooring	2011	22,900	916	25	916		4,141	33
34	TOTAL (lines 1 thru 33)		\$ 5,906,863	\$ 158,999		\$ 153,532	\$ (5,467)	\$ 3,035,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 12B, Carried Forward		\$ 5,906,863	\$ 158,999		\$ 153,532	\$ (5,467)	\$ 3,035,724	1
2	Dining rm exhaust hood & fan	2011	5,408	216	25	216		977	2
3	Dining rm cabinetry & counter top	2011	7,688	769	10	769		3,476	3
4	Dining rm constr:walls-windows-doors,heat-a/c,plumbing,electrica	2011	463,862	8,508	45	10,308	1,800	47,520	4
5	Hall 2 fencing	2011	2,996	300	10	300		1,363	5
6	Sprinkler system improvements	2011	30,617	3,062	10	3,062		12,886	6
7	Two heat pumps	2011	4,991	499	10	499		2,256	7
8	Garbage Disposal	2011	2,684	537	5	537		2,326	8
9	Kitchen heat pump	2011	5,140	514	10	514		2,226	9
10	WI FI	2012	12,791	1,599	8	1,599		6,396	10
11	Sprinkler Heads	2012	12,531	1,253	10	1,253		5,012	11
12	Fire Supression Hall 1 & 2	2012	6,582	658	10	658		2,522	12
13	Hall 3 Remodeling - flooring, fixtures, electrical, wallpaper, painti	2012	180,019	7,201	25	7,201		27,604	13
14	Sprinkler system repair	2012	2,913	582	15	582		1,989	14
15	Heat Pumps	2012	4,655	466	10	466		1,538	15
16	Landscaping / Drainage work	2012	1,606	80	20	80		253	16
17	Front Entry Way redesign, Energy Efficient Double Door Entry, F	2013	44,485	1,779	25	1,779		4,893	17
18	Hall 4 Renovation- New flooring, rewiring, Heat Pumps, Lighting,	2013	136,756	5,470	25	5,470		13,675	18
19	Front Entry Way - Lobby flooring and molding	2013	1,925	77	25	77		212	19
20	Hall 4 Flooring	2013	11,545	1,155	10	1,155		2,887	20
21	Roof Replacement	2013	11,765	588	20	588		1,372	21
22	Nurses Station Flooring	2013	12,699	1,270	10	1,270		2,646	22
23	4 new Heat Pumps	2013	9,026	903	10	903		2,390	23
24	Blacktop Parking lot	2013	32,917	1,646	20	1,646		3,566	24
25	Roof Replacement -office, entrance, dining, laundry & maint room	2014	21,305	1,065	20	1,065		1,420	25
26	Hall 2 Renovations - Wall boards, painting and fixtures	2014	11,215	1,122	10	1,122		1,683	26
27	Hall 2 Renovations - electrical, walls and wall protections	2014	66,001	2,640	25	2,640		3,960	27
28	Install New Fire Alarm System	2014	126,875	5,075	25	5,075		7,312	28
29	Build New Entryway for Kitchen	2014	3,161	316	10	316		474	29
30	Dining Room Remodel- Flooring, Cabinets & Countertops	2014	12,540	1,254	10	1,254		1,881	30
31	Replace 2 heat pumps	2014	5,439	544	10	544		1,088	31
32	New Heat Pump/ A/C installed in ceiling	2014	3,849	770	5	770		1,027	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,162,849	\$ 210,917		\$ 207,250	\$ (3,667)	\$ 3,204,554	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snyder Village

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12C, Carried Forward		\$ 7,162,849	\$ 210,917		\$ 207,250	\$ (3,667)	\$ 3,204,554	1
2	New Carpeting - Hall 2	2015	27,962	2,796	10	2,796		2,796	2
3	Complete Fire Alarm System	2015	14,794	986	15	986		986	3
4	Electrical Wiring - 3 Rooms in Hall 2	2015	919	37	25	37		37	4
5	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	61,421	768	20	768		768	5
6	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	9,766	81	20	81		81	6
7	New Flooring - Dining Room	2015	3,362		10				7
8	Electrical Wiring - 3 Rooms in Hall 2	2015	2,807	257	10	257		257	8
9	Replace Heat Pumps	2015	3,696	370	10	370		370	9
10	Install New Elevator Pit	2015	4,180	174	10	174		174	10
11	Nurse Call System	2015	86,784	2,893	10	2,893		2,893	11
12	Walk In Cooler	2015	10,538	966	10	966		966	12
13	Wanderguard System	2015	8,800	807	10	807		807	13
14	Replace Heat Pumps	2015	7,413	185	10	185		185	14
15	New Cabinets and Countertops - Dining Room	2015	4,282		10				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)		\$ 7,409,573	\$ 221,237		\$ 217,570	\$ (3,667)	\$ 3,214,874	34

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 Costs-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	\$ 784,309	\$ 95,910	\$ 95,910	\$	various	\$ 540,583	71
72	Current Year Purchases	48,114	3,047	3,047		3-10 yrs	3,047	72
73	Fully Depreciated Assets	886,718				various	886,718	73
74								74
75	TOTALS	\$ 1,719,141	\$ 98,957	\$ 98,957	\$		\$ 1,430,348	75

D. Vehicle Costs. (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	Nurse on Call	2002 Chevy Caviliar	2010	4,548	\$	\$	\$	4	\$ 4,548	76
77	Patient Transport	2010 Transit Connect XLT	2015	18,623	1,552	1,552		5	1,552	77
78										78
79										79
80	TOTALS			\$ 23,171	\$ 1,552	\$ 1,552	\$		\$ 6,100	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)	\$ 9,196,185	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 321,746	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 318,079	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,667)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,651,322	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		\$	92
93			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

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								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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,114 Description: Copier

(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	<u>N/A</u>				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

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?</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.</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		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	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8				
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service			Units	Cost								
1	Licensed Occupational Therapist	10A(3)	hrs	\$	12,150	\$	167,614	\$	12,150	\$	167,614	1			
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,603		93,581		3,603		93,581	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist	10A(2,3)	hrs		17,704		307,613		17,704		312,021	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						220,032		220,032	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10			
11	Academic Education		hrs									11			
12	Other (specify): <u>Massage Therapist</u>	10A(1)	2114		30,467				2,114		30,467	12			
13	Other (specify):											13			
14	TOTAL			\$	30,467		33,457	\$	568,808	\$	224,440	35,571	\$	823,715	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 Snyder Village

0033647

Report Period Beginning: 1/1/15

Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 657,810	\$ 657,810	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>59,000</u>)	1,372,621	1,372,621	3
4	Supply Inventory (priced at <u>FIFO</u>)	33,144	33,144	4
5	Short-Term Investments			5
6	Prepaid Insurance	135,887	135,887	6
7	Other Prepaid Expenses	951	951	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany Receivable</u>	827,408	827,408	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,027,821	\$ 3,027,821	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,615,636	1,615,636	12
13	Land	44,300	44,300	13
14	Buildings, at Historical Cost	7,681,052	7,409,573	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,357,369	1,742,312	16
17	Accumulated Depreciation (book methods)	(4,396,997)	(4,651,322)	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): <u>Construction in Progress</u>	8,563	8,563	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,309,923	\$ 6,169,062	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,337,744	\$ 9,196,883	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 196,333	\$ 196,333	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,034	127,034	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,353	11,353	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>Other Accrued Liabilities</u>	19,786	19,786	36
37	<u>Accrued 401K Plan</u>	93,671	93,671	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 448,177	\$ 448,177	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	531,742	531,742	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)	\$ 531,742	\$ 531,742	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 979,919	\$ 979,919	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,357,825	\$ 8,216,964	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,337,744	\$ 9,196,883	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,942,229	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,942,229	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	415,596	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)	\$ 415,596	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)	\$ 8,357,825	24 *

* 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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,325,152	1
2	Discounts and Allowances for all Levels	(2,130,978)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,194,174	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,620	6
7	Oxygen	103,625	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 234,245	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	114	12
13	Barber and Beauty Care	4,675	13
14	Non-Patient Meals	85,801	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	426,500	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,619	20
21	Other Medical Services	141,859	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 674,568	23
D. Non-Operating Revenue			
24	Contributions	497,012	24
25	Interest and Other Investment Income***	(138,405)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 358,607	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Service Fee Income</u>	274,704	28
28a	<u>See Pg 19A</u>	6,673	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 281,377	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,742,971	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,507,510	31
32	Health Care	4,053,752	32
33	General Administration	1,763,871	33
B. Capital Expense			
34	Ownership	345,926	34
C. Ancillary Expense			
35	Special Cost Centers	427,504	35
36	Provider Participation Fee	228,812	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,327,375	40
41	Income before Income Taxes (line 30 minus line 40)**	415,596	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 415,596	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,191,764	44
45	Private Pay - Net Inpatient Revenue	4,099,802	45
46	Medicare - Net Inpatient Revenue	1,513,258	46
47	Other-(specify) <u>Insurance</u>	389,350	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,194,174	49

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Snyder Village

Period Beginning 1/1/15
Period End 12/31/15

Schedule 19A

Amount

XVII. INCOME STATEMENT

Line 28a- Other Income

Van Income	4,875
Miscellaneous Income	1,293
Gain/Loss on Sale of Securities	5
Gain on Sale of Asset	500
Total	<u><u>6,673</u></u>

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	1,617	1,899	\$ 81,856	\$ 43.10	1
2	Assistant Director of Nursing	1,952	2,080	72,119	34.67	2
3	Registered Nurses	20,666	22,863	584,286	25.56	3
4	Licensed Practical Nurses	16,846	18,526	373,197	20.14	4
5	CNAs & Orderlies	92,880	101,348	1,297,641	12.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,940	2,114	30,467	14.41	8
9	Activity Director	1,845	2,080	39,031	18.76	9
10	Activity Assistants	9,736	9,931	110,330	11.11	10
11	Social Service Workers	4,602	5,244	90,870	17.33	11
12	Dietician	3,083	3,590	75,177	20.94	12
13	Food Service Supervisor	1,835	2,059	33,536	16.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,592	30,557	317,726	10.40	15
16	Dishwashers					16
17	Maintenance Workers	8,357	9,036	165,102	18.27	17
18	Housekeepers	16,270	18,404	209,456	11.38	18
19	Laundry	4,032	4,596	55,827	12.15	19
20	Administrator	1,992	2,128	97,274	45.71	20
21	Assistant Administrator					21
22	Other Administrative	1,848	2,080	122,344	58.82	22
23	Office Manager	1,812	2,080	62,515	30.06	23
24	Clerical	11,701	12,794	239,352	18.71	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) See Sch 20A	18,525	20,413	461,723	22.62	33
34	TOTAL (lines 1 - 33)	250,131	273,822	\$ 4,519,829 *	\$ 16.51	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	275	\$ 13,239	L1, C3	35
36	Medical Director	Qtrly	250	L9, C3	36
37	Medical Records Consultant	40	2,523	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,032	L10, C3	39
40	Physical Therapy Consultant	Monthly	9,871	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	3,357	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) Memory Care	Monthly	4,480	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	367	\$ 39,752		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	281	\$ 8,183	L10, C3	50
51	Licensed Practical Nurses	2,560	86,127	L10, C3	51
52	Certified Nurse Assistants/Aides	5,833	110,594	L10, C3	52
53	TOTAL (lines 50 - 52)	8,674	\$ 204,904		53

SEE ACCOUNTANTS' COMPILATION REPORT

Snyder Village

Period Beginning 1/1/15
Period End 12/31/15

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nursing Support	3,610	4,040	96,250	23.82
Admission Nurse	762	762	17,912	23.51
Care Plan Coordinator	3,669	4,254	120,088	28.23
Ward Clerk	3,496	3,811	54,934	14.41
CNA Coordinator	1,700	1,873	43,640	23.30
Transportation	761	761	8,245	10.83
Development	4,527	4,912	120,654	24.56
TOTAL	<u>18,525</u>	<u>20,413</u>	<u>461,723</u>	

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		
Keith Swartzentruber	Exec Director	0	\$ 122,344	Workers' Compensation Insurance	\$ 173,922	IDPH License Fee	\$ 3,980		
Timothy Wiley	Administrator	0	97,274	Unemployment Compensation Insurance	10,000	Advertising: Employee Recruitment	8,387		
				FICA Taxes	334,200	Health Care Worker Background Check			
				Employee Health Insurance	230,862	(Indicate # of checks performed 60)	1,470		
				Employee Meals		Patient Background Checks	203		
				Illinois Municipal Retirement Fund (IMRF)*			2,030		
				Employee Pension Plan	98,362	Misc Dues & Licenses	1,503		
				Employee Life/Disability	2,127	Life Services Network of IL	7,688		
				Employee Flex Time	(8,018)	Relias Learning	2,520		
				Hep B & Employee Physicals	6,672				
				Employee Appreciation	31,573	Less: Public Relations Expense	()		
				Employee Wellness	1,381	Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 219,618	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 27,578	
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		
N/A				N/A			Out-of-State Travel		
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		
							See Attached Schedule		
							Entertainment Expense		
							()		
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							TOTAL		\$ 9,408

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Snyder Village

Period Beginning **1/1/15**
Period End **12/31/15**

Schedule XIX C. Professional Fees

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Heinold - Banwart	Accounting	35,958
Templin Healthcare Accounting	Cost Report Preparation	4,375
Davis & Campbell L.L.C.	Legal	3,607
Johnson, Bunce & Noble	Legal	2,347
	Total	<u>46,287</u>

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/15

Ending:

12/31/15

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. 7,688 Life Services Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,894 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 228,812
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 85,801
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.