

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0005363</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Snyder's-Vaughn Haven, Inc.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>135 S. Morgan St.</u> <u>Rushville</u> <u>62681</u>																									
Number City Zip Code																									
County: <u>Schuyler</u>																									
Telephone Number: <u>(217) 322-3420</u> Fax # <u>(217) 322-6537</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>												
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	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																								
Date of Initial License for Current Owners: <u>1966</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u> Email Address: _____																									

Facility Name & ID Number Snyder's-Vaughn Haven, Inc. # 0005363 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	182,020	30,494		212,514		212,514		212,514			1
2	Food Purchase		128,088		128,088		128,088	(2,214)	125,874			2
3	Housekeeping	61,740	971		62,711		62,711		62,711			3
4	Laundry	52,014	7,636		59,650		59,650		59,650			4
5	Heat and Other Utilities			82,088	82,088		82,088		82,088			5
6	Maintenance	32,398	37,813	45,951	116,162		116,162		116,162			6
7	Other (specify):*											7
8	TOTAL General Services	328,172	205,002	128,039	661,213		661,213	(2,214)	658,999			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	886,020	46,164	5,354	937,538		937,538		937,538			10
10a	Therapy			435,135	435,135		435,135		435,135			10a
11	Activities	20,467	1,330		21,797		21,797		21,797			11
12	Social Services	14,942		3,840	18,782		18,782		18,782			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	921,429	47,494	444,329	1,413,252		1,413,252		1,413,252			16
	C. General Administration											
17	Administrative	109,365			109,365		109,365		109,365			17
18	Directors Fees											18
19	Professional Services			23,852	23,852		23,852		23,852			19
20	Dues, Fees, Subscriptions & Promotions			22,549	22,549		22,549	(1,932)	20,617			20
21	Clerical & General Office Expenses	50,333	5,726	28,229	84,288		84,288		84,288			21
22	Employee Benefits & Payroll Taxes			161,126	161,126		161,126		161,126			22
23	Inservice Training & Education			1,395	1,395		1,395		1,395			23
24	Travel and Seminar			619	619		619		619			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,126	48,126		48,126		48,126			26
27	Other (specify):*											27
28	TOTAL General Administration	159,698	5,726	285,896	451,320		451,320	(1,932)	449,388			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,409,299	258,222	858,264	2,525,785		2,525,785	(4,146)	2,521,639			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							58,483	58,483			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,916	4,916		4,916	25,033	29,949			32
33	Real Estate Taxes			39,465	39,465		39,465		39,465			33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles			4,364	4,364		4,364		4,364			35
36	Other (specify):*											36
37	TOTAL Ownership			168,745	168,745		168,745	(36,484)	132,261			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		100,456		100,456		100,456		100,456			39
40	Barber and Beauty Shops			1,099	1,099		1,099		1,099			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,808	66,808		66,808		66,808			42
43	Other (specify):* Non-Allow Costs			28,336	28,336		28,336	(28,336)				43
44	TOTAL Special Cost Centers		100,456	96,243	196,699		196,699	(28,336)	168,363			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,409,299	358,678	1,123,252	2,891,229		2,891,229	(68,966)	2,822,263			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(912)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,981)	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	26,571	30		9
10	Interest and Other Investment Income	(137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,854)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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 Pg 5A	(25,735)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,048)		\$	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 Amount	2 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)	(62,918)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (62,918)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (68,966)		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 Yes	2 No	3 Amount	4 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

Report Period Beginning:

Ending:

ID#

0005363

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lab Services	\$ (21,028)	43	1
2	Non-allowable lobbying dues	(1,932)	20	2
3				3
4	Medicare treatments	(1,473)	43	4
5	Vending Income	(1,302)	2	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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32				32
33				33
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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	(25,735)		49

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
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%	25,170	25,170	2
3	V	34	Rent	120,000	Snyder Properties	100.00%		(120,000)	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			\$ 120,000			\$ 57,082	\$ * (62,918)	14

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

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	Total			\$			\$ 0	\$ * 0	39

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

Facility Name & ID Number Snyder's-Vaughn Haven, Inc. # 0005363 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	\$ 66,394	17(1)	1
2	Marcia Dianne Snyder	DON	Nursing Admin.	0.00	N/A	50	100.00	Salary	45,569	10(1)	2
3	Aaron Snyder	Clerical	Clerical	0.00	N/A	40	100.00	Salary	17,138	21(1)	3
4	Gregg Snyder	Maintenance	Maintenance	0.00	N/A	40	100.00	Salary	18,541	6(1)	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 147,642		13

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

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

Facility Name & ID Number Snyder's-Vaughn Haven, Inc. # 0005363 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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

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

	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		<u>N/A</u>				\$	\$			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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	First Bank		X	Mortgage	\$13,445.00	11/01/95	\$ 1,133,854	\$ 388,408	11/07/15	0.0894	\$ 25,170	1	
2	Schuyler State Bank		X	Vehicle purchase	\$696.00	03/16/05	42,127	(281)	03/16/10	0.0590		2	
3												3	
4												4	
5												5	
	Working Capital												
6	Schuyler State Bank		X	Line of Credit	Varies	09/30/05	125,000	198,443	09/30/08	0.0850	4,916	6	
7												7	
8												8	
9	TOTAL Facility Related				\$14,141.00		\$ 1,300,981	\$ 586,570			\$ 30,086	9	
	B. Non-Facility Related*												
10												10	
11												11	
12									Offset interest income		(137)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (137)	14	
15	TOTALS (line 9+line14)						\$ 1,300,981	\$ 586,570			\$ 29,949	15	

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

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

** 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 2010 report.			\$	30,000	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.)		2010	\$	39,465	2
3. Under or (over) accrual (line 2 minus line 1).			\$	9,465	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	30,000	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.			\$	39,465	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	36,588	8	
		2007	37,515	9	
		2008	37,426	10	
		2009	40,046	11	
		2010	39,380	12	
Accrual - same as last year.					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Snyder's-Vaughn Haven, Inc.

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 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>12-040-013-00&12-131-007-00</u>	<u>Nursing Home</u>	\$ <u>341.32</u>	\$ <u>341.32</u>
2. <u>12-170-012-00&12-126-005-00</u>	<u>Nursing Home</u>	\$ <u>570.32</u>	\$ <u>570.32</u>
3. <u>12-131-008-00</u>	<u>Nursing Home</u>	\$ <u>348.18</u>	\$ <u>348.18</u>
4. <u>12-170-014-00</u>	<u>Nursing Home</u>	\$ <u>1,640.44</u>	\$ <u>1,640.44</u>
5. <u>12-131-003-00</u>	<u>Nursing Home</u>	\$ <u>177.50</u>	\$ <u>177.50</u>
6. <u>12-131-009-00</u>	<u>Nursing Home</u>	\$ <u>216.98</u>	\$ <u>216.98</u>
7. <u>12-125-001-00</u>	<u>Nursing Home</u>	\$ <u>249.36</u>	\$ <u>249.36</u>
8. <u>12-126-004-00</u>	<u>Nursing Home</u>	\$ <u>399.54</u>	\$ <u>399.54</u>
9. <u>12-126-003-00</u>	<u>Nursing Home</u>	\$ <u>35,228.24</u>	\$ <u>35,228.24</u>
10. <u>12-126-006-00</u>	<u>Nursing Home</u>	\$ <u>293.16</u>	\$ <u>293.16</u>
TOTALS		\$ <u>39,465.04</u>	\$ <u>39,465.04</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

46,354

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

2

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

Facility Name & ID Number Snyder's-Vaughn Haven, Inc.

0005363

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	99		1992		\$ 1,276,487	\$	40	\$ 31,912	\$ 31,912	\$ 610,479
5										
6										
7										
8										
	Improvement Type**									
9	Prior Years				173,475		Various			173,475
10	Drop Ceiling		1993		1,046		15			1,046
11	Alarm System		1996		9,173		10			9,173
12	Boiler		1996		2,242		10			2,242
13	Landscaping		1997		3,684		10			3,684
14	Roof		1997		3,427		10			3,427
15	Carpet		1997		3,080		10			3,080
16	Door		1997		4,494		10			4,494
17	Boiler		1997		503		10			503
18	A/C - Compressor		1997		839		10			839
19	Boiler		1999		2,840		10			2,840
20	Air Conditioner		1999		3,500		10			3,500
21	Fire Alarm System		1999		55,739		10			55,739
22	Parking Lot		1999		55,214		10			55,214
23	Landscaping		2000		23,959		10	2,396	2,396	25,158
24	Fire Alarm System		2000		7,032		10	704	704	7,736
25	Concrete Sidewalks and Drive		2000		3,379		10	338	338	3,717
26	Landscaping		2000		1,079		10	108	108	342
27	Concrete Sidewalks and Drive		2000		535		10	54	54	589
28	Plumbing Improvements		2000		2,257		10	226	226	2,483
29	Wall Coverings		2000		2,870		10	286	286	3,156
30	Electrical Improvements		2000		1,243		10	124	124	1,367
31	Door Frame		2000		791		10	80	80	871
32	Water Softner		2001		6,543		10	654	654	6,867
33	Landscaping		2001		1,804		10	180	180	1,890
34	Roofing		2001		2,934		10	293	293	3,077
35	Door Locks		2002		2,783		10	278	278	2,641
36	Storage		2003		7,281		10	728		6,188

*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

Facility Name & ID Number Snyder's-Vaughn Haven, Inc.

0005363

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	Air Conditioners	2004	\$ 6,477	\$	10	\$ 648	\$ 648	\$ 4,860	37
38	Air Conditioners	2004	16,031		10	1,604	1,604	12,030	38
39	Air Conditioner	2005	4,700		10	470	470	3,055	39
40	Fire Alarm System	2005	3,379		10	338	338	2,197	40
41	Boiler	2005	2,728		10	272	272	1,768	41
42	Sidewalks	2005	4,286		10	428	428	2,782	42
43	Gutters	2005	1,326		10	132	132	858	43
44	Landscaping	2005	2,003		10	200	200	1,300	44
45	Sidewalks	2005	4,497		10	450	450	2,925	45
46	Air Conditioners	2005	14,630		10	1,463	1,463	9,510	46
47	Gazebo	2005	12,974		10	1,298	1,298	8,437	47
48	Boiler	2006	2,703		10	270	270	1,485	48
49									49
50	Purchase & Installation of new hydraulic cylinder	2008	33,887		10	3,389	3,389	11,861	50
51									51
52									52
53	Replacement Doors	2009	6,526		10	653	653	1,632	53
54									54
55	Heating Boiler	2010	4,429		10	443	443	664	55
56	Hot Water Heater	2010	3,693		10	369	369	554	56
57	A/C Units	2010	10,930		10	1,093	1,093	1,640	57
58	Removal of old house	2010	4,000		10	400	400	600	58
59	Boiler	2011	11,227		15	374	374	374	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,810,659	\$		\$ 52,655	\$ 51,927	\$ 1,064,349	70

**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	\$ 793,151	\$	\$ 5,494	\$ 5,494	5-10	\$ 775,991	71
72	Current Year Purchases	4,676		334	334	7	334	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 797,827	\$	\$ 5,828	\$ 5,828		\$ 776,325	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	See Schedule 13A	See Schedule 13A	See Sch 13A	\$ 30,300	\$	\$	\$	5	\$ 30,300	76
77	Resident Care	99 Chrysler van	2004	11,850				5	11,850	77
78	Resident Care	04 Ford Bus	2005	42,109				5	42,109	78
79	Maintenance	2005 Dodge Truck	2004	34,438				5	34,438	79
80	TOTALS			\$ 118,697	\$	\$	\$		\$ 118,697	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,800,183	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,483	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 58,483	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,959,371	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.

Snyder's Vaughn-Haven, Inc.

Provider #: 0005363
1/1/2011 to 12/31/2011

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		255	0	5	2,541
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
			30,300	-	508	0		30,300

SEE ACCOUNTANTS' COMPILATION REPORT

Snyder's Vaughn-Haven, Inc.
Provider #:
1/1/2010 to

XI (D) - Vehicle Depreciation

Line 76

Use	Make & Model
Maintenance	2005 Dodge Cab Upgrade
Maintenance	1990 Dodge van
Maintenance	1995 Dodge truck
Administrative	1997 Plymouth Neon

0005363
12/31/2010

Schedule 13A

Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accum Depreciation
2005	2,541		255	0	5	2,541
1991	8,633			-	5	8,633
1996	11,665			-	5	11,665
1997	7,461			-	5	7,461
	30,300	-	508	0		30,300

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				N/A			4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- 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: \$ 4,364
- Description: Copier \$3802, Equipment \$ 562
- (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			\$ N/A	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,252	435,135		7,252	435,135	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				100,456		100,456	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			\$	7,252	\$ 435,135	\$ 100,456	7,252	\$ 535,591	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.

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	\$ 456,144	\$ 456,144	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance ;-0-)	1,813,140	1,813,140	3
4	Supply Inventory (priced at)	1,195	1,195	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)	44,796	44,796	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,345,715	\$ 2,345,715	10
	B. Long-Term Assets			
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	247,162	1,810,659	15
16	Equipment, at Historical Cost	246,495	916,524	16
17	Accumulated Depreciation (book methods)	(294,926)	(1,959,371)	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>Property Tax</u>	6,543	6,543	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 205,274	\$ 847,355	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,550,989	\$ 3,193,070	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 299,079	\$ 299,079	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	232,629	232,629	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	133,116	133,116	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Liabilities</u>	63,199	63,199	36
37	<u>See Schedule 17A</u>	275,697	275,697	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,033,720	\$ 1,033,720	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	198,162	198,162	39
40	Mortgage Payable		388,408	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)	\$ 198,162	\$ 586,570	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,231,882	\$ 1,620,290	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,319,107	\$ 1,572,780	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,550,989	\$ 3,193,070	48

*(See instructions.)

Snyder's Vaughn-Haven, Inc.
Provider # 0005363
01/01/11 to 12/31/11

Schedule 17A

XV: Special Services		After	
Line 37- Other Current Liabilities		<u>Operating</u>	<u>Consolidation</u>
V.I Snyder Loan	169,907	169,907	
J.R. Snyder Loan	99,298	99,298	
Resident Refunds	609	609	
Due to JRSCC	5,883	5,883	
	<u>275,697</u>	<u>275,697</u>	

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 859,423	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 859,423	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	459,684	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 459,684	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)	\$ 1,319,107	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,507,809	1
2	Discounts and Allowances for all Levels	17,772	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,525,581	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	690,515	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 690,515	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	912	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	96,258	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,738	19
20	Radiology and X-Ray	448	20
21	Other Medical Services	19,022	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 133,378	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	137	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 137	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	1,302	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,302	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,350,913	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	661,213	31
32	Health Care	1,413,252	32
33	General Administration	451,320	33
	B. Capital Expense		
34	Ownership	168,745	34
	C. Ancillary Expense		
35	Special Cost Centers	129,891	35
36	Provider Participation Fee	66,808	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,891,229	40
41	Income before Income Taxes (line 30 minus line 40)**	459,684	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 459,684	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.

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

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	2,080	2,080	\$ 49,095	\$ 23.60	1
2	Assistant Director of Nursing	2,339	2,409	55,502	23.04	2
3	Registered Nurses	3,662	3,712	67,881	18.29	3
4	Licensed Practical Nurses	16,981	17,549	272,196	15.51	4
5	CNAs & Orderlies	43,098	44,796	441,346	9.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,135	20,467	9.59	9
10	Activity Assistants					10
11	Social Service Workers	800	800	14,942	18.68	11
12	Dietician					12
13	Food Service Supervisor	2,099	2,190	29,572	13.50	13
14	Head Cook	8,641	9,026	79,083	8.76	14
15	Cook Helpers/Assistants	5,333	5,508	49,052	8.91	15
16	Dishwashers	2,767	2,839	24,313	8.56	16
17	Maintenance Workers	3,085	3,259	32,398	9.94	17
18	Housekeepers	7,010	7,238	61,740	8.53	18
19	Laundry	5,563	5,946	52,014	8.75	19
20	Administrator	2,080	2,080	69,879	33.60	20
21	Assistant Administrator	2,080	2,080	39,486	18.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,605	5,665	50,333	8.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,263	119,312	\$ 1,409,299 *	\$ 11.81	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	254	5,354	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)	350	\$ 9,194		49

C. CONTRACT NURSES

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

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

** See instructions.

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	\$ 69,879	Workers' Compensation Insurance	\$	40,096	IDPH License Fee	\$ 4,080
David Grate	Asst. Administrator	0	39,486	Unemployment Compensation Insurance		11,115	Advertising: Employee Recruitment	10,332
				FICA Taxes		105,237	Health Care Worker Background Check	
				Employee Health Insurance			(Indicate # of checks performed _____)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Illinois Health Care Association	5,465
				Other Employee Relations & Benefits		4,678	Miscellaneous Licenses & Fees	379
							Miscellaneous Dues	2,293
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Non-allowable Dues	
(List each licensed administrator separately.)			\$ 109,365				Less: IHCA Lobbying Dues @ 35.36%	(1,932)
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				Non-allowable advertising	()
N/A			\$				Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$	161,126	TOTAL (agree to Sch. V,	
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners	Unemployment Services	\$	1,156	N/A		\$	Out-of-State Travel	\$
Elevator Safety Services	Inspect Elevator		160					
Computer Masters	Computer		1,255					
Jennifer Schroeder MD	Medical Director		2,400				In-State Travel	
RSM McGladrey	Accounting		14,475					
Schuyler Cty Clerk	Claim Filing		0					
Duane Morris	Legal		1,989					
Vision Share Inc	Data Processing		1,238				Seminar Expense	619
Simple LTC	Data Processing		974					
John R. Snyder	Consulting		205					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 23,852				(agree to Sch. V,	
							line 24, col. 8)	\$ 619

* Attach copy of IMRF notifications

**See instructions.

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?

7

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 4,918

Line 10(2)

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 66,808

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.

\$ 912

(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 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.