

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>Snyders-Vaughn Haven</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/12</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.																																																	
Address: <u>135 South Morgan Street</u> <u>Rushville</u> <u>62681</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Schuyler</u>																																																			
Telephone Number: <u>(217) 322-3420</u> Fax # <u>(217) 322-6537</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>1966</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☒</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</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:																																																			
Name: <u>Larry Templin</u>																																																			
Telephone Number: <u>(630) 361-2868</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>John Snyder</u>																																																	
		(Title) <u>Administrator</u>																																																	
		(Signed) _____ (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>																																																	
		(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, Illinois 61525</u>																																																	
		(Telephone) <u>(630) 361-2868</u> Fax # ()																																																	
		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																																																	

Facility Name & ID Number Snyders-Vaughn Haven# 0005363 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,934</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,300</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	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	<u>2,285</u>	<u>300</u>	<u>1,825</u>	<u>4,410</u>	8
9	SNF/PED					9
10	ICF	<u>9,820</u>	<u>10,252</u>		<u>20,072</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,105</u>	<u>10,552</u>	<u>1,825</u>	<u>24,482</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.57%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. 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 1966

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

YES ☒Date 1992NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 49 and days of care provided 1,825Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	194,890	45,694		240,584		240,584		240,584		1
2	Food Purchase		148,070		148,070		148,070	(2,101)	145,969		2
3	Housekeeping	72,465	845		73,310		73,310		73,310		3
4	Laundry	56,819	4,688		61,507		61,507		61,507		4
5	Heat and Other Utilities			83,284	83,284		83,284		83,284		5
6	Maintenance	48,777	41,741	44,186	134,704		134,704		134,704		6
7	Other (specify):*										7
8	TOTAL General Services	372,951	241,038	127,470	741,459		741,459	(2,101)	739,358		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	994,651	50,404	6,053	1,051,108		1,051,108		1,051,108		10
10a	Therapy		500	411,414	411,914		411,914		411,914		10a
11	Activities	21,121	1,341	984	23,446		23,446		23,446		11
12	Social Services	38,229	82	3,840	42,151		42,151		42,151		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,054,001	52,327	422,291	1,528,619		1,528,619		1,528,619		16
	C. General Administration										
17	Administrative	111,566			111,566		111,566		111,566		17
18	Directors Fees										18
19	Professional Services			24,353	24,353		24,353		24,353		19
20	Dues, Fees, Subscriptions & Promotions			9,561	9,561		9,561	(1,526)	8,035		20
21	Clerical & General Office Expenses	128,185	7,675	40,194	176,054		176,054	(251)	175,803		21
22	Employee Benefits & Payroll Taxes			191,628	191,628		191,628		191,628		22
23	Inservice Training & Education			1,712	1,712		1,712		1,712		23
24	Travel and Seminar			5,370	5,370		5,370	(3,694)	1,676		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,715	96,715		96,715		96,715		26
27	Other (specify):*										27
28	TOTAL General Administration	239,751	7,675	369,533	616,959		616,959	(5,471)	611,488		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,666,703	301,040	919,294	2,887,037		2,887,037	(7,572)	2,879,465		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			56,433	56,433		56,433	2,747	59,180			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,644	10,644		10,644	27,493	38,137			32
33	Real Estate Taxes			38,825	38,825		38,825		38,825			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			8,234	8,234		8,234		8,234			35
36	Other (specify):*											36
37	TOTAL Ownership			258,136	258,136		258,136	(113,760)	144,376			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		85,673		85,673		85,673		85,673			39
40	Barber and Beauty Shops			1,174	1,174		1,174		1,174			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			280,575	280,575		280,575		280,575			42
43	Other (specify):* Non-allowable Costs			99,802	99,802		99,802	(99,802)				43
44	TOTAL Special Cost Centers		85,673	381,551	467,224		467,224	(99,802)	367,422			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,666,703	386,713	1,558,981	3,612,397		3,612,397	(221,134)	3,391,263			45

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

		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	(690)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,023)	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	(29,165)	30		9
10	Interest and Other Investment Income	(841)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,304)	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	(46,149)	43		24
25	Fund Raising, Advertising and Promotional	(13,726)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax	(4,733)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(35,749)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (137,380)		\$	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)	(83,754)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (83,754)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (221,134)		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

Snyders-Vaughn Haven

Report Period Beginning:1/1/2012

Ending:12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Lab Services	\$ (25,965)	43	1
2	Non-allowable lobbying dues	(1,526)	20	2
3	Medicare treatments	(2,902)	43	3
4	Vending Income	(1,411)	2	4
5	Miscellaneous Income Offset	(251)	21	5
6	Out of state travel & seminar	(3,694)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(35,749)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Snyders-Vaughn Haven

0005363

Report Period Beginning:

1/1/2012

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,101)	0	0	0	0	0	0	0	0	0	0	(2,101)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,101)	0	0	0	0	0	0	0	0	0	0	(2,101)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	20
21	Clerical & General Office Expenses	(251)	0	0	0	0	0	0	0	0	0	0	(251)	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	(3,694)	0	0	0	0	0	0	0	0	0	0	(3,694)	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	(5,471)	0	0	0	0	0	0	0	0	0	0	(5,471)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,572)	0	0	0	0	0	0	0	0	0	0	(7,572)	29

Summary B

12/31/12

[illegible]

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.

[illegible]

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	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Line	Item		Name of Related Organization				
1	V	30	Depreciation	\$	Snyder Properties	100.00%	\$ 31,912	\$ 31,912	1
2	V	32	Interest		Snyder Properties	100.00%	28,334	28,334	2
3	V	34	Rent	144,000	Snyder Properties	100.00%		(144,000)	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			\$ 144,000			\$ 60,246	\$ * (83,754)	14

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

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	\$ 70,566	L17, C1	1
2	Marcia Dianne Snyder	DON	Nursing Admin.	0.00	N/A	50	100.00	Salary	49,360	L10, C1	2
3	Aaron Snyder	Clerical	Clerical	0.00	N/A	40	100.00	Salary	18,856	L21, C1	3
4	Gregg Snyder	Maintenance	Maintenance	0.00	N/A	40	100.00	Salary	20,318	L6, C1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 159,100		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 Snyders-Vaughn Haven

0005363

Report Period Beginning:

1/1/2012

Ending: 12/31/12

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

N/A

Street Address

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					\$	\$		\$	1
2	N/A								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 Mid Illinois		X	Mortgage	\$8,249.45	11/2012	\$ 1,250,000	\$ 1,247,573	11/2032	0.0500	\$ 28,334	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Schuyler State Bank		X	Line of Credit	Varies	09/30/05	125,000	149,074	9/30/13	0.0850	10,644	6
7	JP Morgan Chase		X	Vehicle	\$623.40	12/20/12	33,878	33,597	2/3/2018	0.0390		7
8												8
9	TOTAL Facility Related				\$8,872.85		\$ 1,408,878	\$ 1,430,244			\$ 38,978	9
	B. Non-Facility Related*											
10												10
11									Offset interest income		(841)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (841)	14
15	TOTALS (line 9+line14)						\$ 1,408,878	\$ 1,430,244			\$ 38,137	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 2011 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.)		2011	\$	38,825	2
3. Under or (over) accrual (line 2 minus line 1).		\$	8,825		3
4. Real Estate Tax accrual used for 2012 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.		\$	38,825		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	37,515	8	
		2008	37,426	9	
		2009	40,046	10	
		2010	39,380	11	
		2011	38,825	12	
Accrual based on prior year tax bill.					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyders-Vaughn Haven COUNTY Schuyler
FACILITY IDPH LICENSE NUMBER 0005363
CONTACT PERSON REGARDING THIS REPORT John R. Snyder
TELEPHONE (217) 322-3201 FAX #: (217) 322-6537

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>12-040-013-00&12-131-007-00</u>	<u>Nursing Home</u>	\$ <u>335.60</u>	\$ <u>335.60</u>
2.	<u>12-170-012-00&12-126-005-00</u>	<u>Nursing Home</u>	\$ <u>563.26</u>	\$ <u>563.26</u>
3.	<u>12-131-008-00</u>	<u>Nursing Home</u>	\$ <u>193.38</u>	\$ <u>193.38</u>
4.	<u>12-170-014-00</u>	<u>Nursing Home</u>	\$ <u>1,620.14</u>	\$ <u>1,620.14</u>
5.	<u>12-131-003-00</u>	<u>Nursing Home</u>	\$ <u>175.30</u>	\$ <u>175.30</u>
6.	<u>12-131-009-00</u>	<u>Nursing Home</u>	\$ <u>214.34</u>	\$ <u>214.34</u>
7.	<u>12-125-001-00</u>	<u>Nursing Home</u>	\$ <u>246.32</u>	\$ <u>246.32</u>
8.	<u>12-126-004-00</u>	<u>Nursing Home</u>	\$ <u>394.64</u>	\$ <u>394.64</u>
9.	<u>12-126-003-00</u>	<u>Nursing Home</u>	\$ <u>34,792.66</u>	\$ <u>34,792.66</u>
10.	<u>12-126-006-00</u>	<u>Nursing Home</u>	\$ <u>289.60</u>	\$ <u>289.60</u>
TOTALS			\$ <u><u>38,825.24</u></u>	\$ <u><u>38,825.24</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ☒ YES ☐ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: _____
(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	<u>Resident Care</u>	<u>215,000</u>	<u>1992</u>	<u>\$ 41,500</u>	1
2	<u>Resident Care</u>		<u>1997</u>	<u>31,500</u>	2
3	TOTALS	215,000		\$ 73,000	3

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

0005363

Report Period Beginning:

1/1/2012

Ending:

12/31/12

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	\$ 642,391
5										
6										
7										
8										
	Improvement Type**									
9	Prior Years				173,475	82	Various		(82)	173,475
10	Drop Ceiling		1993		1,046	33	15		(33)	1,046
11	Alarm System		1996		9,173		10			9,173
12	Boiler		1996		2,242		10			2,242
13	Landscaping		1997		3,684	109	10		(109)	3,684
14	Roof		1997		3,427	88	10		(88)	3,427
15	Carpet		1997		3,080	79	10		(79)	3,080
16	Door		1997		4,494	115	10		(115)	4,494
17	Boiler		1997		503	13	10		(13)	503
18	A/C - Compressor		1997		839	22	10		(22)	839
19	Boiler		1999		2,840	73	10		(73)	2,840
20	Air Conditioner		1999		3,500	90	10		(90)	3,500
21	Fire Alarm System		1999		55,739		10			55,739
22	Parking Lot		1999		55,214	2,955	10		(2,955)	55,214
23	Landscaping		2000		23,959		10			23,959
24	Fire Alarm System		2000		7,032		10			7,032
25	Concrete Sidewalks and Drive		2000		3,379	200	10		(200)	3,379
26	Landscaping		2000		1,079	64	10		(64)	1,079
27	Concrete Sidewalks and Drive		2000		535	32	10		(32)	535
28	Plumbing Improvements		2000		2,257	303	10		(303)	2,257
29	Wall Coverings		2000		2,870		10			2,870
30	Electrical Improvements		2000		1,243		10			1,243
31	Door Frame		2000		791		10			791
32	Water Softner		2001		6,543	112	10		(112)	6,543
33	Landscaping		2001		1,804		10			1,804
34	Roofing		2001		2,934	75	10		(75)	2,934
35	Door Locks		2002		2,783		10	142	142	2,783
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

Facility Name & ID Number Snyder-Vaughn Haven

0005363

Report Period Beginning:

1/1/2012

Ending:

12/31/12

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	
37	Storage	2003	\$ 7,281	\$ 123	10	\$ 728	\$ 605	\$ 6,916	37
38	Air Conditioners	2004	6,477		10	648	648	5,508	38
39	Air Conditioners	2004	16,031		10	1,604	1,604	13,634	39
40	Air Conditioner	2005	4,700	171	10	470	299	3,525	40
41	Fire Alarm System	2005	3,379	123	10	338	215	2,535	41
42	Boiler	2005	2,728	99	10	272	173	2,040	42
43	Sidewalks	2005	4,286	253	10	428	175	3,210	43
44	Gutters	2005	1,326	48	10	132	84	990	44
45	Landscaping	2005	2,003	118	10	200	82	1,500	45
46	Sidewalks	2005	4,497	265	10	450	185	3,375	46
47	Air Conditioners	2005	14,630	532	10	1,463	931	10,973	47
48	Gazebo	2005	12,974	472	10	1,298	826	9,735	48
49	Boiler	2006	2,703	98	10	270	172	1,755	49
50									50
51	Purchase & Installation of new hydraulic cylinder	2008	33,887		10	3,389	3,389	15,250	51
52									52
53									53
54	Replacement Doors	2009	6,526	237	10	653	416	2,285	54
55									55
56	Heating Boiler	2010	4,429	176	10	443	267	1,107	56
57	Hot Water Heater	2010	3,693	134	10	369	235	923	57
58	A/C Units	2010	10,930	397	10	1,093	696	2,733	58
59	Removal of old house	2010	4,000		10	400	400	1,000	59
60	Boiler	2011	11,227	408	15	1,123	715	1,497	60
61	Concrete Driveway and Sidewalk	2012	8,534	988	15	284	(704)	284	61
62	Boiler	2012	7,153	54	15	238	184	238	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,826,346	\$ 9,141		\$ 48,347	\$ 39,206	\$ 1,109,869	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	\$ 797,827	\$ 584	\$ 6,162	\$ 5,578	5-10	\$ 782,487	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 797,827	\$ 584	\$ 6,162	\$ 5,578		\$ 782,487	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	Resident Care	04 Ford Bus	2005	\$ 42,109	\$	\$	\$	5	\$ 42,109	76
77	Administrative	2005 Chrysler Town & Country	2012	12,830	12,830	1,283	(11,547)	5	1,283	77
78	Maintenance	2013 Dodge Truck Ram 1500	2012	33,878	33,878	3,388	(30,490)	5	3,388	78
79										79
80	TOTALS			\$ 88,817	\$ 46,708	\$ 4,671	\$ (42,037)		\$ 46,780	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)	\$ 2,785,990 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,433 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,180 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,747 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,939,136 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.

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

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. /2013 \$
13. /2014 \$
14. /2015 \$

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: \$ 8,234 Description: Copier \$4,945, Medical Equipment \$3,289
(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

* 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	10A(3)	hrs	\$	9,385	\$ 197,503	\$	9,385	\$ 197,503	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		284	17,223		284	17,223	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		9,618	196,688	500	9,618	197,188	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				85,673		85,673	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			\$	19,287	\$ 411,414	\$ 86,173	19,287	\$ 497,587	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
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	\$ 592,718	\$ 592,718	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,861,982	1,861,982	3
4	Supply Inventory (priced at <u>Cost</u>)	1,195	1,195	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,924	21,924	6
7	Other Prepaid Expenses	13,466	13,466	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)	\$ 2,536,081	\$ 2,536,081	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		1,276,487	14
15	Leasehold Improvements, at Historical Cost	262,849	549,859	15
16	Equipment, at Historical Cost	251,305	886,644	16
17	Accumulated Depreciation (book methods)	(322,786)	(1,939,136)	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)	\$ 197,911	\$ 853,397	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,733,992	\$ 3,389,478	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 315,317	\$ 315,317	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,986	219,986	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			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Liabilities</u>	62,730	62,730	36
37	<u>See Schedule 17A</u>	275,418	275,418	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 903,451	\$ 903,451	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	182,671	182,671	39
40	Mortgage Payable		1,247,573	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)	\$ 182,671	\$ 1,430,244	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,086,122	\$ 2,333,695	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,647,870	\$ 1,055,783	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,733,992	\$ 3,389,478	48

*(See instructions.)

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

Schedule 17A

XV: Special Services	After	
	Operating	Consolidation
Line 37- Other Current Liabilities		
V.I Snyder Loan	169,907	169,907
J.R. Snyder Loan	99,298	99,298
Resident Refunds	530	530
Due to JRSCC	5,683	5,683
	<u>275,418</u>	<u>275,418</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,319,107	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(13,326)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,305,781	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	342,089	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)	\$ 342,089	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)	\$ 1,647,870	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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,710,145	1
2	Discounts and Allowances for all Levels	(6,745)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,703,400	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	121,586	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 121,586	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	1,411	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	690	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,935	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,322	19
20	Radiology and X-Ray		20
21	Other Medical Services	28,050	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 128,408	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	841	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 841	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income (Offset in Col 7, P3)	251	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 251	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,954,486	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	741,459	31
32	Health Care	1,528,619	32
33	General Administration	616,959	33
	B. Capital Expense		
34	Ownership	258,136	34
	C. Ancillary Expense		
35	Special Cost Centers	186,649	35
36	Provider Participation Fee	280,575	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,612,397	40
41	Income before Income Taxes (line 30 minus line 40)**	342,089	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 342,089	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,335,047	44
45	Private Pay - Net Inpatient Revenue	1,585,343	45
46	Medicare - Net Inpatient Revenue	783,010	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,703,400	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? No-Note A 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.
Note A-This entity is a cash basis tax payer

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	\$ 59,520	\$ 28.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,344	2,405	50,914	21.17	3
4	Licensed Practical Nurses	13,058	18,651	328,505	17.61	4
5	CNAs & Orderlies	50,337	52,180	555,712	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,019	2,095	21,121	10.08	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	38,229	18.38	11
12	Dietician					12
13	Food Service Supervisor	2,169	2,313	26,549	11.48	13
14	Head Cook	7,065	7,365	68,467	9.30	14
15	Cook Helpers/Assistants	10,365	10,554	99,874	9.46	15
16	Dishwashers					16
17	Maintenance Workers	4,599	4,777	48,777	10.21	17
18	Housekeepers	7,733	7,919	72,465	9.15	18
19	Laundry	5,811	6,100	56,819	9.31	19
20	Administrator	2,080	2,080	70,566	33.93	20
21	Assistant Administrator	2,080	2,080	41,000	19.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,650	7,719	103,788	13.45	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) <u>MDS Coord</u>	1,561	1,629	24,397	14.98	33
34	TOTAL (lines 1 - 33)	123,031	132,027	\$ 1,666,703 *	\$ 12.62	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	Monthly	2,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,558	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	984	L11, C3	44
45	Social Service Consultant	Monthly	3,840	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,782		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Snyders-Vaughn Haven

0005363

Report Period Beginning:

1/1/2012

Page 21

Ending:

12/31/12

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	\$ 70,566	Workers' Compensation Insurance		\$ 42,146	IDPH License Fee		\$	
David Grate		Asst. Administrator	0	41,000	Unemployment Compensation Insurance		12,760	Advertising: Employee Recruitment			
					FICA Taxes		128,380	Health Care Worker Background Check			
					Employee Health Insurance			(Indicate # of checks performed 28)		810	
					Employee Meals			Patient Background Checks		55 650	
					Illinois Municipal Retirement Fund (IMRF)*			Illinois Health Care Association		4,099	
					Other Employee Relations & Benefits		8,342	Miscellaneous Licenses & Fees		1,537	
TOTAL (agree to Schedule V, line 17, col. 1)								Miscellaneous Dues		2,465	
(List each licensed administrator separately.)				\$ 111,566				Less: Non-allowable Dues			
B. Administrative - Other								Less: IHCA Lobbying Dues @ 37.23%		(1,526)	
Description				Amount				Less: Public Relations Expense		()	
N/A				\$				Non-allowable advertising		()	
								Yellow page advertising		()	
								TOTAL (agree to Sch. V,		\$ 8,035	
					TOTAL (agree to Schedule V,		\$ 191,628	line 20, col. 8)			
					line 22, col.8)						
TOTAL (agree to Schedule V, line 17, col. 3)				\$	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)					to Owners or Employees			Description		Amount	
C. Professional Services					Description		Line #	Amount	Out-of-State Travel		\$
Vendor/Payee		Type		Amount							
Personnel Planners		Unemployment Services		\$ 792							
Elevator Safety Services		Inspect Elevator		160							
Capodice & Associates		Accounting		1,400	N/A						
RSM McGladrey		Accounting		12,931							
Legat Architect		Architect		3,335							
Duane Morris		Legal		1,103							
Charles A. Burton		Legal		45							
Hartzell, Gliddon, Tucker & Hartzel		Legal		545							
Ability		Data Processing		3,068							
Simple LTC		Data Processing		974							
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$		Seminar Expense		1,676
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 24,353					Entertainment Expense		()
									(agree to Sch. V,		
									line 24, col. 8)		\$ 1,676

* Attach copy of IMRF notifications

**See instructions.

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. 4,099 IHCA

(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.

\$ 6,389 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.

N/A

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

\$ 280,575

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. \$ 690

(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.