

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0033647</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Snyder Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</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>1200 East Partridge</u> <u>Metamora</u> <u>61548</u>																									
Number City Zip Code																									
County: <u>Woodford</u>																									
Telephone Number: <u>(309) 367-4300</u> Fax # <u>(309) 367-2235</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) <u>Keith Swartzentruber</u></td></tr><tr><td>(Title) <u>Executive Director</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Keith Swartzentruber</u>	(Title) <u>Executive Director</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	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, IL 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												
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	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																								
Date of Initial License for Current Owners: <u>1988</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 <u>501 (c) 3</u></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 <u>501 (c) 3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☒ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Keith Swartzentruber</u> Telephone Number: <u>(309) 367-4300</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village

0033647 Report Period Beginning: 1/1/16 Ending: 12/31/16

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>104</u>	Skilled (SNF)	<u>104</u>	<u>38,064</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>104</u>	TOTALS	<u>104</u>	<u>38,064</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,828</u>	<u>19,750</u>	<u>4,932</u>	<u>33,510</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,828</u>	<u>19,750</u>	<u>4,932</u>	<u>33,510</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.04%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Out-patient Therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 104 and days of care provided 3,588

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 1/1/16 Ending: 12/31/16
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	414,332	23,214	18,270	455,816		455,816	(41,664)	414,152			1
2	Food Purchase		329,359		329,359		329,359	(73,543)	255,816			2
3	Housekeeping	188,825	35,381	1,007	225,213		225,213		225,213			3
4	Laundry	80,978	11,272		92,250		92,250		92,250			4
5	Heat and Other Utilities			132,706	132,706		132,706		132,706			5
6	Maintenance	175,563	59,132	33,233	267,928		267,928	(30,982)	236,946			6
7	Other (specify):* Waste Removal			817	817		817		817			7
8	TOTAL General Services	859,698	458,358	186,033	1,504,089		1,504,089	(146,189)	1,357,900			8
	B. Health Care and Programs											
9	Medical Director			300	300		300		300			9
10	Nursing and Medical Records	2,605,485	204,319	538,621	3,348,425		3,348,425	(19,152)	3,329,273			10
10a	Therapy											10a
11	Activities	168,487	12,365	3,327	184,179		184,179	3,525	187,704			11
12	Social Services	87,727	916	9,676	98,319		98,319		98,319			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,861,699	217,600	551,924	3,631,223		3,631,223	(15,627)	3,615,596			16
	C. General Administration											
17	Administrative	224,393			224,393		224,393	(62,874)	161,519			17
18	Directors Fees											18
19	Professional Services			113,011	113,011		113,011	(599)	112,412			19
20	Dues, Fees, Subscriptions & Promotions			38,951	38,951		38,951	(940)	38,011			20
21	Clerical & General Office Expenses	308,961	26,471	24,748	360,180		360,180	(151,905)	208,275			21
22	Employee Benefits & Payroll Taxes			835,486	835,486		835,486		835,486			22
23	Inservice Training & Education			525	525		525		525			23
24	Travel and Seminar			15,488	15,488		15,488	(940)	14,548			24
25	Other Admin. Staff Transportation			3,017	3,017		3,017		3,017			25
26	Insurance-Prop.Liab.Malpractice			79,555	79,555		79,555		79,555			26
27	Other (specify):*											27
28	TOTAL General Administration	533,354	26,471	1,110,781	1,670,606		1,670,606	(217,258)	1,453,348			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,254,751	702,429	1,848,738	6,805,918		6,805,918	(379,074)	6,426,844			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			345,683	345,683		345,683	(3,778)	341,905			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,814	15,814		15,814	(2,875)	12,939			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,053	3,053		3,053		3,053			35
36	Other (specify):*											36
37	TOTAL Ownership			364,550	364,550		364,550	(6,653)	357,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	33,517	245,497	606,600	885,614		885,614	(3,432)	882,182			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			237,679	237,679		237,679		237,679			42
43	Other (specify):* Disallowed Costs	118,918		269,819	388,737		388,737	(388,737)				43
44	TOTAL Special Cost Centers	152,435	245,497	1,114,098	1,512,030		1,512,030	(392,169)	1,119,861			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,407,186	947,926	3,327,386	8,682,498		8,682,498	(777,896)	7,904,602			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(73,543)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,432)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,778)	30		9
10	Interest and Other Investment Income	(2,875)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,193)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(599)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(197,388)	43		24
25	Fund Raising, Advertising and Promotional	(169,441)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(315,647)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (777,896)		\$	30

BHF USE ONLY							
48		49		50		51	

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (777,896)		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Service Fee income - Administrative	\$ (31,437)	17	1
2	Offset Service Fee income - Administrative	(54,211)	21	2
3	Offset Service Fee income - Administrative	52,324	43	3
4	Offset Service Fee income - Marketing/fundraising	(7,824)	43	4
5	Offset Service Fee income/exp - Activities/Trans	4,152	11	5
6	Offset Service Fee income - Dietary	(41,664)	1	6
7	Offset Service Fee income - Maintenance	(28,788)	6	7
8	Offset Service Fee income - Therapy	(3,432)	39	8
9	Offset Service Fee income - Nursing	(19,152)	10	9
10	Offset Service Fee income - Administrative	(31,437)	17	10
11	Offset Service Fee income - Administrative	(96,325)	21	11
12	Offset Service Fee income - Administrative	(36,806)	43	12
13	Offset Misc. Other Revenue	(742)	21	13
14	Disallow Brokerage Fees	(14,977)	43	14
15	Offset Purchase Rebates	(2,194)	6	15
16	Offset Purchase Rebates	(940)	20	16
17	Offset Purchase Rebates	(940)	24	17
18	Offset Purchase Rebates	(627)	21	18
19	Offset Purchase Rebates	(627)	11	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	(315,647)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(41,664)	0	0	0	0	0	0	0	0	0	0	(41,664)	1
2	Food Purchase	(73,543)	0	0	0	0	0	0	0	0	0	0	(73,543)	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	(30,982)	0	0	0	0	0	0	0	0	0	0	(30,982)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(146,189)	0	0	0	0	0	0	0	0	0	0	(146,189)	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	(19,152)	0	0	0	0	0	0	0	0	0	0	(19,152)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	3,525	0	0	0	0	0	0	0	0	0	0	3,525	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	(15,627)	0	0	0	0	0	0	0	0	0	0	(15,627)	16
	C. General Administration													
17	Administrative	(62,874)	0	0	0	0	0	0	0	0	0	0	(62,874)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(599)	0	0	0	0	0	0	0	0	0	0	(599)	19
20	Fees, Subscriptions & Promotions	(940)	0	0	0	0	0	0	0	0	0	0	(940)	20
21	Clerical & General Office Expenses	(151,905)	0	0	0	0	0	0	0	0	0	0	(151,905)	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	(940)	0	0	0	0	0	0	0	0	0	0	(940)	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	(217,258)	0	0	0	0	0	0	0	0	0	0	(217,258)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(379,074)	0	0	0	0	0	0	0	0	0	0	(379,074)	29

Summary B

12/31/16

[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.

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

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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors:							1
2								2
3	Lois Lampe - Secretary							3
4	Judy Winkler - President							4
5	Tammy Waterworth - Vice President							5
6	Greg Minger							6
7	Bill Christ							7
8	Kevin Brinkman							8
9	Diane Gravlin							9
10	Tom Brock - Treasurer							10
11	Dawson Hooley							11
12	Greg Pilon							12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 _____
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										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Commerce Bank		X	Building	\$5,270.00	8/1/87	\$ 3,450,000	\$ 169,951	9/1/26	0.0167	\$ 3,474	1	
2	Goodfield State Bank		X	Building	\$1,700.00	12/1/12	300,000	253,687	12/1/27	0.0325	8,595	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Gift Annuity		X	Building	\$510.00	Various	84,000	32,623	Various	0.0675	3,745	6	
7												7	
8												8	
9	TOTAL Facility Related				\$7,480.00		\$ 3,834,000	\$ 456,261			\$ 15,814	9	
	B. Non-Facility Related*												
10												10	
11							Interest Income offset				(2,875)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,875)	14	
15	TOTALS (line 9+line14)						\$ 3,834,000	\$ 456,261			\$ 12,939	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	N/A	8	
		2012	N/A	9	
		2013	N/A	10	
		2014	N/A	11	
		2015	N/A	12	
This facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for the real estate tax is required.				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyder Village COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0033647

CONTACT PERSON REGARDING THIS REPORT Keith Swartzentruber

TELEPHONE (309) 367-4300 FAX #: (309) 367-2235

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 36,870
- B. General Construction Type: Exterior BrickFrame Wood & SteelNumber of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

Snyder Village Retirement Community Apartments - 41 Apartments @ 38,793 Ft2
Snyder Village Retirement Community Cottages - 170 Cottages @ approximately 318,000 Ft2
Snyder Village Assisted Living - 65 units @ approximately 45,900 Ft2

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	61		1988	1988	\$ 1,929,231	\$ 42,872	45	\$ 42,872	\$	\$ 1,221,850	4
5			1992	1992	127,495	2,833	45	2,833		69,647	5
6			1992	1992	33,830	1,353	25	1,353		32,699	6
7	18		1994	1994	600,872	13,353	45	13,353		304,891	7
8	26		1994	1994	1,256,597	27,924	45	27,924		616,658	8
	Improvement Type**										
9	Fire Control System			1989	5,152		20			5,152	9
10	Century Tub			1989	7,694		10			7,694	10
11	Asphalt			1990	1,820		20			1,820	11
12	Alzheimer's Courtyard			1990	3,644		10			3,644	12
13	Heat Exchanger			1990	1,650		10			1,650	13
14	Tub			1991	1,465		10			1,465	14
15	Door Locks			1991	1,400		20			1,400	15
16	Door Locks			1992	1,200		20			1,200	16
17	Patio			1992	1,219		10			1,219	17
18	Entrance Light			1993	619		10			619	18
19	Land Improvement			1994	25,546		20			25,546	19
20	Services Windows			1995	198,184	4,481	45	4,481		95,841	20
21	Landscaping			1995	8,221		20	692	692	13,052	21
22	Canopy			1995	1,102		20			1,102	22
23	Electrical Maintenance			1995	595		15			595	23
24	Door Locks			1995	505		15			505	24
25	Front Canopy			1996	44,780	999	45	999		19,463	25
26	Tower			1996	7,360	123	20	123		7,360	26
27	Door Open			1996	3,344		10			3,344	27
28	Landscaping			1997	1,500	75	20	75		1,463	28
29	Front Door Wiring			1997	1,396	70	20	70		1,387	29
30	Kelly Glass			1998	3,527	176	20	176		3,345	30
31	MTCO Phone System			1998	10,865	757	25	757		12,877	31
32	Carpet			1998	15,719		10			15,719	32
33	Heater			1999	1,784		10			1,784	33
34	Security Camera			1999	2,510		15			2,510	34
35	Motion Detector			1999	790		10			790	35
36	Shelving			1999	673		10			673	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic Door Open	2000	\$ 5,449	\$	15	\$	\$	\$ 5,449	37
38	Blacktop	2000	21,736	1,087	20	1,087		17,482	38
39	Sunroom	2000	86,294	1,920	45	1,920		31,677	39
40	Generator	2000	35,213	1,810	20	1,810		29,791	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,716		10			5,714	42
43	Nursing Office Addition	2001	759,951	16,707	45	16,707		259,049	43
44	Nurse Office Addition	2001	4,943	247	20	247		3,890	44
45	Blacktop	2001		603	20		(603)	8,543	45
46	Roof	2002	36,779	2,452	15	2,452		35,759	46
47	Hall 2 Room Alert	2002	5,015		5			5,015	47
48	Door, Tile, Drapes, Wall	2003	4,557		8			4,557	48
49	Door	2004	1,640		3			1,640	49
50	Roam Alert	2004	4,488		5			4,488	50
51	Carpet Hall 2	2004	856		5			856	51
52	Drapery	2004	2,335		5			2,335	52
53	Heat Pump	2005	1,051		10			1,051	53
54	Water Heater	2005	4,240		10			4,240	54
55	Therapy room door	2005	755		5			755	55
56	Hall 1 Nurses Station	2005	9,010	451	20	451		5,073	56
57	Service Door	2005	950		3			950	57
58	Blacktop Sealcoat	2005	3,373		5			3,373	58
59	Disposal unit	2006		19	10		(19)		59
60	Heat pump	2006	4,981	125	10	125		4,981	60
61	Air conditioning unit	2006			5				61
62	Heat pump	2006	4,260	285	10	285		4,260	62
63	Hall carpeting	2006	21,377	2,219	10		(2,219)	21,377	63
64	Sidewalk	2006		45	20		(45)		64
65	Alarm system	2007	3,304		5			3,304	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,338,351	\$ 122,986		\$ 120,792	\$ (2,194)	\$ 2,952,362	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,338,351	\$ 122,986		\$ 120,792	\$ (2,194)	\$ 2,952,362	1
2	Heat pump	2007	9,181	918	10	918		9,178	2
3	Hall 2 flooring	2007		2,747	10		(2,747)		3
4	Front signage	2008	15,386	1,539	10	1,539		12,696	4
5	Blacktop	2008	15,488	774	20	774		6,319	5
6	Heat Pump	2008	10,609	1,061	10	1,061		9,018	6
7	Rm flooring, wall & window covering, wood work, windows	2009	40,354	2,018	20	2,018		14,629	7
8	Energy management system controls	2009	19,344	1,934	10	1,934		15,467	8
9	Plumbing & sprinkler system	2009	21,157	1,937	10	1,937		16,235	9
10	Thermo systems	2009		181	10		(181)		10
11	Fencing	2009		91	10		(91)		11
12	Courtyard landscaping	2009	2,539	254	10	254		1,841	12
13	Cable TV wiring	2009	33,168	4,146	8	4,146		29,704	13
14	Heat Pump	2010	16,061	1,606	10	1,606		10,305	14
15	Motion Detector & Electrical Fixtures	2010	9,081	908	10	908		5,903	15
16	Blacktop	2010	27,905	1,395	20	1,395		9,070	16
17	Schrepfer front door	2010	3,766	377	10	377		2,356	17
18	Heat Pump halls 1, 2, 3	2011	10,345	1,035	10	1,035		6,122	18
19	Health Center Hall1 Room Design/Drawings/Engineering	2011	13,665	1,367	10	1,367		8,085	19
20	Wall mounted shadow box & bulletin board	2011	2,528	253	10	253		1,496	20
21	Light fixtures, switches, outlets, breakers, wiring	2011	36,050	1,442	25	1,442		8,530	21
22	Toilets, sinks, faucets, piping, grab bar, lav top	2011	9,847	393	25	393		2,325	22
23	Corner & medicine cabinet, headboards	2011	9,053	905	10	905		5,353	23
24	Wall studs, wall board, paint, trim & guards	2011	6,120	245	25	245		1,449	24
25	Curtains w/track	2011	3,386	339	10	339		2,005	25
26	Chair rail & oak light boxes	2011	6,234	249	25	249		1,473	26
27	Window blinds & valances	2011	8,247	330	25	330		1,952	27
28	Wall protection 4'x8' sheets for resident rooms	2011	26,660	1,066	25	1,066		5,885	28
29	Health Center Hall1 Dining Rm Design/Drawings/Engineering	2011	124,070	2,757	45	2,757		15,220	29
30	Dining room flooring	2011	20,000	800	25	800		4,416	30
31	Hall 1 & 13 resident room flooring	2011	22,900	916	25	916		5,057	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,861,495	\$ 156,969		\$ 151,756	\$ (5,213)	\$ 3,164,451	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,861,495	\$ 156,969		\$ 151,756	\$ (5,213)	\$ 3,164,451	1
2	Dining rm exhaust hood & fan	2011	5,408	216	25	216		1,193	2
3	Dining rm cabinetry & counter top	2011	4,700	470	10	470		3,946	3
4	Dining rm constr:walls-windows-doors,heat-a/c,plumbing,electrical	2011	463,862	8,607	45	10,308	1,701	57,828	4
5	Hall 2 fencing	2011	2,996	300	10	300		1,663	5
6	Sprinkler system improvements	2011	27,961	3,062	10	2,796	(266)	15,682	6
7	Two heat pumps	2011	4,991	499	10	499		2,755	7
8	Garbage Disposal	2011	2,684	358	5	358		2,684	8
9	Kitchen heat pump	2011	5,140	514	10	514		2,740	9
10	WI FI	2012	12,791	1,599	8	1,599		7,995	10
11	Sprinkler Heads	2012	12,531	1,253	10	1,253		6,265	11
12	Fire Supression Hall 1 & 2	2012	6,582	658	10	658		3,180	12
13	Hall 3 Remodeling - flooring, fixtures, electrical, wallpaper, paint	2012	180,019	7,201	25	7,201		34,805	13
14	Sprinkler system repair	2012	2,913	582	15	582		2,571	14
15	Heat Pumps	2012	4,655	466	10	466		2,004	15
16	Landscaping / Drainage work	2012	1,606	80	20	80		333	16
17	Front Entry Way redesign, Energy Efficient Double Door Entry, F	2013	44,485	1,779	25	1,779		6,672	17
18	Hall 4 Renovation- New flooring, rewiring, Heat Pumps, Lighting,	2013	136,756	5,470	25	5,470		19,145	18
19	Front Entry Way - Lobby flooring and molding	2013	1,925	77	25	77		289	19
20	Hall 4 Flooring	2013	11,545	1,155	10	1,155		4,042	20
21	Roof Replacement	2013	11,765	588	20	588		1,960	21
22	Nurses Station Flooring	2013	12,699	1,270	10	1,270		3,916	22
23	4 new Heat Pumps	2013	9,026	903	10	903		3,293	23
24	Blacktop Parking lot	2013	32,917	1,646	20	1,646		5,212	24
25	Roof Replacement -office, entrance, dining, laundry & maint room	2014	21,305	1,065	20	1,065		2,485	25
26	Hall 2 Renovations - Wall boards, painting and fixtures	2014	11,215	1,121	10	1,121		2,804	26
27	Hall 2 Renovations - electrical, walls and wall protections	2014	66,001	2,640	25	2,640		6,600	27
28	Install New Fire Alarm System	2014	126,875	5,075	25	5,075		12,387	28
29	Build New Entryway for Kitchen	2014	3,161	316	10	316		790	29
30	Dining Room Remodel- Flooring, Cabinets & Countertops	2014	12,540	1,254	10	1,254		3,135	30
31	Replace 2 heat pumps	2014	5,439	544	10	544		1,632	31
32	New Heat Pump/ A/C installed in ceiling	2014	3,849	770	5	770		1,797	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,111,837	\$ 208,507		\$ 204,729	\$ (3,778)	\$ 3,386,254	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,111,837	\$ 208,507		\$ 204,729	\$ (3,778)	\$ 3,386,254	1
2	New Carpeting - Hall 2	2015	27,962	2,796	10	2,796		5,592	2
3	Complete Fire Alarm System	2015	14,794	986	15	986		1,972	3
4	Electrical Wiring - 3 Rooms in Hall 2	2015	919	37	25	37		74	4
5	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	61,421	3,071	20	3,071		3,839	5
6	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	9,766	488	20	488		569	6
7	New Flooring - Dining Room	2015	3,362	336	10	336		336	7
8	Electrical Wiring - 3 Rooms in Hall 2	2015	2,807	281	10	281		538	8
9	Replace Heat Pumps	2015	3,696	370	10	370		740	9
10	Install New Elevator Pit	2015	4,180	418	10	418		592	10
11	Nurse Call System	2015	86,784	8,678	10	8,678		11,571	11
12	Walk In Cooler	2015	10,538	1,054	10	1,054		2,020	12
13	Wanderguard System	2015	8,800	880	10	880		1,687	13
14	Replace Heat Pumps	2015	7,413	741	10	741		926	14
15	New Cabinets and Countertops - Dining Room	2015	4,282	428	10	428		428	15
16	New Flooring - Assisted Dining Room	2016	5,637	495	10	495		495	16
17	Replace Bistro Door	2016	1,806	181	10	181		181	17
18	Replace Heat Pumps	2016	6,401	587	10	587		587	18
19	Patio - Maintenance Building	2016	8,000	167	20	167		167	19
20	Door Alarms	2016	4,959	372	10	372		372	20
21	Built-In Whirlpool Tub	2016	15,954	931	10	931		931	21
22	Roofing-Therapy Area	2016	11,739	245	20	245		245	22
23	Roofing - Hall 2	2016	11,127	46	20	46		46	23
24	Sump Pump in Basement	2016	2,884	72	10	72		72	24
25	Cabling for Network System	2016	16,000	267	10	267		267	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,443,068	\$ 232,434		\$ 228,656	\$ (3,778)	\$ 3,420,501	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 779,195	\$ 93,210	\$ 93,210	\$	various	\$ 583,612	71
72	Current Year Purchases	208,687	16,314	16,314		3-10 yrs	16,314	72
73	Fully Depreciated Assets	939,946				various	939,946	73
74								74
75	TOTALS	\$ 1,927,828	\$ 109,524	\$ 109,524	\$		\$ 1,539,872	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nurse on Call	2002 Chevy Caviliar	2010	4,548	\$	\$	\$	4	\$ 4,548	76
77	Patient Transport	2010 Transit Connect XLT	2015	18,623	3,725	3,725		5	5,277	77
78										78
79										79
80	TOTALS			\$ 23,171	\$ 3,725	\$ 3,725	\$		\$ 9,825	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)	\$ 9,438,367	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 345,683	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 341,905	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,778)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,970,198	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$3,053
- Description: Copier
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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	39(3)	hrs	\$	9,904	\$ 160,460	\$	9,904	\$ 160,460	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,355	74,041		2,355	74,041	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), 39(3)	hrs		14,611	336,478	4,891	14,611	341,369	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				240,606		240,606	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Massage Therapist</u>		2119	33,517				2,119	33,517	12
13	Other (specify): _____									13
14	TOTAL			\$ 33,517	26,870	\$ 570,979	\$ 245,497	28,989	\$ 849,993	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 327,866	\$ 327,866	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,000)	1,841,169	1,841,169	3
4	Supply Inventory (priced at FIFO)	48,195	48,195	4
5	Short-Term Investments			5
6	Prepaid Insurance	134,633	134,633	6
7	Other Prepaid Expenses	3,654	3,654	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany Receivable	410,205	410,205	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,765,722	\$ 2,765,722	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,509,160	2,509,160	12
13	Land	44,300	44,300	13
14	Buildings, at Historical Cost	7,901,094	7,443,068	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,430,521	1,950,999	16
17	Accumulated Depreciation (book methods)	(4,742,681)	(4,970,198)	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): Construction in Progress	1,472	1,472	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,143,866	\$ 6,978,801	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,909,588	\$ 9,744,523	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 273,360	\$ 273,360	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	154,725	154,725	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,737	12,737	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Liabilities	28,338	28,338	36
37	Accrued 401K Plan	66,592	66,592	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 535,752	\$ 535,752	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	456,261	456,261	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 456,261	\$ 456,261	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 992,013	\$ 992,013	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,917,575	\$ 8,752,510	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,909,588	\$ 9,744,523	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,357,825	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,357,824	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	559,751	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)	\$ 559,751	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,917,575	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,746,756	1
2	Discounts and Allowances for all Levels	(1,959,813)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,786,943	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	230,730	6
7	Oxygen	65,306	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 296,036	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	18	12
13	Barber and Beauty Care	4,221	13
14	Non-Patient Meals	73,543	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	22,154	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	151,007	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 250,943	23
	D. Non-Operating Revenue		
24	Contributions	410,370	24
25	Interest and Other Investment Income***	189,986	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 600,356	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Service Fee Income	294,600	28
28a	See Pg 19A	13,371	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 307,971	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,242,249	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,504,089	31
32	Health Care	3,631,223	32
33	General Administration	1,670,606	33
	B. Capital Expense		
34	Ownership	364,550	34
	C. Ancillary Expense		
35	Special Cost Centers	1,274,351	35
36	Provider Participation Fee	237,679	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,682,498	40
41	Income before Income Taxes (line 30 minus line 40)**	559,751	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 559,751	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,043,302	44
45	Private Pay - Net Inpatient Revenue	4,676,788	45
46	Medicare - Net Inpatient Revenue	1,501,983	46
47	Other-(specify) <u>Insurance</u>	564,870	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,786,943	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village

Period Beginning 1/1/16
Period End 12/31/16

Schedule 19A

Amount

XVII. INCOME STATEMENT

Line 28a- Other Income

Van Income	7,114
Miscellaneous Income	742
Purchase Rebates	6,269
Gain/Loss on Sale of Securities	(754)

Total	<u>13,371</u>
--------------	----------------------

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,588	1,692	\$ 70,645	\$ 41.75	1
2	Assistant Director of Nursing	1,496	1,584	51,481	32.50	2
3	Registered Nurses	13,797	14,991	427,635	28.53	3
4	Licensed Practical Nurses	17,157	18,501	432,400	23.37	4
5	CNAs & Orderlies	86,800	93,337	1,284,675	13.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,924	2,119	33,517	15.82	8
9	Activity Director	1,807	2,001	38,769	19.37	9
10	Activity Assistants	9,492	10,123	119,763	11.83	10
11	Social Service Workers	4,367	4,873	87,727	18.00	11
12	Dietician	2,030	2,174	54,607	25.12	12
13	Food Service Supervisor	1,470	1,677	28,900	17.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,190	29,012	330,825	11.40	15
16	Dishwashers					16
17	Maintenance Workers	8,692	9,425	175,563	18.63	17
18	Housekeepers	14,231	15,518	188,825	12.17	18
19	Laundry	5,845	6,595	80,978	12.28	19
20	Administrator	1,980	2,088	94,083	45.06	20
21	Assistant Administrator					21
22	Other Administrative	1,819	2,080	130,310	62.65	22
23	Office Manager	1,848	2,080	62,491	30.04	23
24	Clerical	11,257	12,130	246,470	20.32	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>See Sch 20A</u>	18,397	19,852	467,522	23.55	33
34	TOTAL (lines 1 - 33)	233,187	251,852	\$ 4,407,186 *	\$ 17.50	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	389	\$ 18,270	L1, C3	35
36	Medical Director	Qtrly	300	L9, C3	36
37	Medical Records Consultant	28	1,889	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,693	L10, C3	39
40	Physical Therapy Consultant	Monthly	10,281	L39, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	3,119	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) <u>Memory Care</u>	Monthly	13,280	L10, C3	46
47	<u>MDS Consultant</u>	703	49,189	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,168	\$ 102,021		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,227	\$ 45,700	L10, C3	50
51	Licensed Practical Nurses	6,395	221,035	L10, C3	51
52	Certified Nurse Assistants/Aides	10,559	201,835	L10, C3	52
53	TOTAL (lines 50 - 52)	18,181	\$ 468,570		53

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village

Period Beginning 1/1/16
Period End 12/31/16

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nursing Support	7,813	8,389	240,696	28.69
Ward Clerk	3,525	3,861	59,919	15.52
CNA Coordinator	1,822	2,011	38,034	18.91
Transportation	750	750	9,955	13.27
Development	4,487	4,841	118,918	24.56
TOTAL	18,397	19,852	467,522	

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning: 1/1/16

Page 21

Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Keith Swartzentruber		Exec Director	0	\$ 130,310	Workers' Compensation Insurance		\$ 118,922	IDPH License Fee		\$	
Timothy Wile		Administrator	0	62,448	Unemployment Compensation Insurance		16,514	Advertising: Employee Recruitment		24,614	
Corrie Magee		Administrator	0	31,635	FICA Taxes		321,247	Health Care Worker Background Check			
					Employee Health Insurance		254,521	(Indicate # of checks performed 32)		928	
					Employee Meals			Patient Background Checks		100 1,000	
					Illinois Municipal Retirement Fund (IMRF)*						
					Employee Pension Plan		54,941	Misc Dues & Licenses		829	
					Employee Life/Disability		1,855	LeadingAge Illinois		7,283	
					Employee Flex Time		22,073	Relias Learning		2,025	
					Hep B & Employee Physicals		8,760	AAIM Employer's Association		1,332	
					Employee Appreciation		33,699	Less: Public Relations Expense		()	
					Employee Wellness		2,954	Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 224,393	TOTAL (agree to Schedule V, line 22, col.8)		\$ 835,486	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 38,011	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description				Amount	Description		Line #	Amount	Description		Amount
N/A				\$	N/A				Out-of-State Travel		\$
									In-State Travel		5,413
TOTAL (agree to Schedule V, line 17, col. 3)				\$					Seminar Expense		9,135
(Attach a copy of any management service agreement)								See Attached Schedule			
C. Professional Services											
Vendor/Payee		Type		Amount							
Matrix		Computer Software		\$ 34,449							
Empower		Computer Service		2,831							
CDS Office Technologies		Computer Service		18,828							
Casamba		Computer Service		4,825							
Ability Ease		Computer Service		667							
Ability Network		Medicare Electronic Filing		5,519							
Sage Software, Inc		Payroll Software		14,223							
E-Health Data Socations		LTC Information Technology		966					Entertainment Expense		()
E-Solutions		Computer Service		3,404					(agree to Sch. V,		
Miscellaneous Vendors		Misc. Computer Software		258					line 24, col. 8)		
ClearPath		Computer Support		6,956					TOTAL		\$ 14,548
See Page 21A				20,085							
TOTAL (agree to Schedule V, line 19, column 3)				\$ 113,011	TOTAL		\$				
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Snyder Village

Period Beginning 1/1/16
Period End 12/31/16

Schedule XIX C. Professional Fees

Vendor/Payee	Type	Amount
Heinold - Banwart	Accounting	12,056
Templin Healthcare Accounting	Cost Report Preparation	4,875
Davis & Campbell L.L.C.	Legal	1,780
Johnson, Bunce & Noble	Legal	599
Ken Reutter	Accounting	775
	Total	20,085

Facility Name & ID Number <u>Snyder Village</u>	STATE OF ILLINOIS # <u>0033647</u>	Report Period Beginning: <u>1/1/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. 7,283 LeadingAge Illinois

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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? 3-10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 57,526 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 237,679
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes: OP Therapy For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 73,543

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
 Firm Name: Heinold-Banwart, Ltd.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
 Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT