

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0033647

Facility Name: Snyder Village

Address: 1200 East Partridge Metamora 61548
Number City Zip Code

County: Woodford

Telephone Number: (309) 367-4300 Fax # (309) 367-2235

HFS ID Number:

Date of Initial License for Current Owners: 6/30/88

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Keith Swartzentruber Telephone Number: (309) 367-4300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 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.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Keith Swartzentruber
(Title) Executive Director

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village

0033647 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>106</u>	Skilled (SNF)	<u>106</u>	<u>38,796</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>106</u>	TOTALS	<u>106</u>	<u>38,796</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>122</u>	<u>120</u>	<u>2,056</u>	<u>2,298</u>	8
9	SNF/PED					9
10	ICF	<u>9,182</u>	<u>21,842</u>		<u>31,024</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,304</u>	<u>21,962</u>	<u>2,056</u>	<u>33,322</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.89 %

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 106 and days of care provided 1,751

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: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	551,481	20,743	14,808	587,032		587,032	(67,404)	519,628			1
2	Food Purchase		312,065		312,065		312,065	(66,775)	245,290			2
3	Housekeeping	202,066	21,054	108	223,228		223,228		223,228			3
4	Laundry	96,831	16,862		113,693		113,693		113,693			4
5	Heat and Other Utilities			119,385	119,385		119,385		119,385			5
6	Maintenance	198,202	34,211	41,338	273,751		273,751	5,726	279,477			6
7	Other (specify):*			856	856		856		856			7
8	TOTAL General Services	1,048,580	404,935	176,495	1,630,010		1,630,010	(128,453)	1,501,557			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,093,122	363,096	584,296	4,040,514		4,040,514	(22,871)	4,017,643			10
10a	Therapy											10a
11	Activities	315,868	8,402	3,307	327,577		327,577	29,376	356,953			11
12	Social Services	108,016	1,156	3,570	112,742		112,742		112,742			12
13	CNA Training											13
14	Program Transportation			3,000	3,000		3,000		3,000			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,517,006	372,654	594,173	4,483,833		4,483,833	6,505	4,490,338			16
	C. General Administration											
17	Administrative	257,619			257,619		257,619	(72,488)	185,131			17
18	Directors Fees											18
19	Professional Services			146,543	146,543		146,543	(655)	145,888			19
20	Dues, Fees, Subscriptions & Promotions			20,469	20,469		20,469	(3,888)	16,581			20
21	Clerical & General Office Expenses	478,939	30,853	32,237	542,029		542,029	(147,814)	394,215			21
22	Employee Benefits & Payroll Taxes			1,204,014	1,204,014		1,204,014	(46,808)	1,157,206			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,947	4,947		4,947		4,947			24
25	Other Admin. Staff Transportation			1,206	1,206		1,206		1,206			25
26	Insurance-Prop.Liab.Malpractice			113,045	113,045		113,045		113,045			26
27	Other (specify):*											27
28	TOTAL General Administration	736,558	30,853	1,522,461	2,289,872		2,289,872	(271,653)	2,018,219			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,302,144	808,442	2,293,129	8,403,715		8,403,715	(393,601)	8,010,114			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			436,556	436,556		436,556	(6,981)	429,575			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,518	8,518		8,518	(33)	8,485			32
33	Real Estate Taxes			252	252		252	(252)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,199	4,199		4,199		4,199			35
36	Other (specify):*											36
37	TOTAL Ownership			449,525	449,525		449,525	(7,266)	442,259			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	22,696	144,500	458,509	625,705		625,705		625,705			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,644	253,644		253,644		253,644			42
43	Other (specify):* Disallowed Costs	114,472		107,754	222,226		222,226	(222,226)				43
44	TOTAL Special Cost Centers	137,168	144,500	819,907	1,101,575		1,101,575	(222,226)	879,349			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,439,312	952,942	3,562,561	9,954,815		9,954,815	(623,093)	9,331,722			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.)

		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	(66,775)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,486)	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	(6,981)	30		9
10	Interest and Other Investment Income	(33)	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	(2,248)	20		17
18	Fines and Penalties	(1,430)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(455)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,990)	43		24
25	Fund Raising, Advertising and Promotional	(157,967)	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	(336,728)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (623,093)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (623,093)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Service Fee income - Administrative	\$ (72,488)	17	1
2	Offset Service Fee income - Administrative	(200)	19	2
3	Offset Service Fee income - Administrative	(1,640)	20	3
4	Offset Service Fee income - Administrative	(141,526)	21	4
5	Offset Service Fee income - Administrative	(46,368)	22	5
6	Offset Service Fee income/exp - Administrative	15,406	43	6
7	Offset Service Fee income - Marketing/fundraising	(2,136)	43	7
8	Offset Service Fee income/exp - Activities/Trans	29,376	11	8
9	Offset Service Fee income - Dietary	(67,404)	1	9
10	Offset Service Fee income - Maintenance	(6,792)	6	10
11	Offset Service Fee income - Nursing	(22,128)	10	11
12	Offset Service Fee income - Administrative	(6,288)	21	12
13	Disallow Brokerage Fees	(25,623)	43	13
14	Offset Purchase Rebates	(2,228)	6	14
15	Offset Purchase Rebates	(743)	10	15
16	Offset Misc. Other Revenue	(440)	22	16
17	Disallow Property Tax Expense	(252)	33	17
18	Expense Leasehold Improvements under \$2,500	14,746	6	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	(336,728)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	Diane Gravlin - President							3
4	Greg Minger - Vice President							4
5	Gary Baranowski - Secretary							5
6	Tom Brock - Treasurer							6
7	Lois Lampe							7
8	Wendee Guth							8
9	Pete Streid							9
10	Lisa Obery							10
11	Gary Salm							11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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									\$		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								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: 1/1/2020 Ending: 2/31/2020

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	Goodfield State Bank		X	Building	\$1,700.00	12/1/12	300,000	203,849	12/1/27	0.0325	7,420	1		
2												2		
3												3		
4												4		
5												5		
	Working Capital													
6	Gift Annuity		X	Building	\$510.00	Various	84,000	8,383	Various	Various	1,098	6		
7												7		
8												8		
9	TOTAL Facility Related				\$2,210.00		\$ 384,000	\$ 212,232			\$ 8,518	9		
	B. Non-Facility Related*													
10												10		
11									Interest Income offset		(33)	11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$ (33)	14		
15	TOTALS (line 9+line14)						\$ 384,000	\$ 212,232			\$ 8,485	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 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	211	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.)		2019		\$	228	2
3. Under or (over) accrual (line 2 minus line 1).				\$	17	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	235	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.		Nonallowable Property Taxes			(252)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(252)	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:		2015	N/A	8		
		2016	N/A	9		
		2017	N/A	10		
		2018	205	11		
		2019	228	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.				13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
Property taxes paid are for farmland/vacant land and have been adjusted out.				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

2019 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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 09-20-228-013	Farmland	\$ 204.54	\$
2. 09-20-228-010	Vacant Land	\$ 23.44	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 227.98	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 46,490

B. General Construction Type: Exterior BrickFrame Wood & Steel

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

Snyder Village Retirement Community Apartments - 41 Apartments @ 38,793 Ft2

Snyder Village Retirement Community Cottages - 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	See Attached Sch 11A			45,050	2
3	TOTALS	155,422		\$ 88,050	3

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 11A

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4		
	Use	Square Feet	Year Acquired	Cost		
1	Nursing Home		2001	\$	1,300	1
2	Nursing Home	43,560	2018		43,750	2
3	TOTALS	43,560		\$	45,050	3

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	60		1988	1988	\$ 1,929,231	\$ 42,872	45	\$ 42,872	\$	\$ 1,393,338	4
5			1992	1992	127,495	2,833	45	2,833		80,979	5
6			1992	1992	33,830		25			33,830	6
7	44		1994	1994	1,857,469	41,277	45	41,277		1,086,657	7
8	2		2019	2019	1,997,104	44,380	45	44,380		77,704	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	4,404	(77)	111,804	20
21	Landscaping			1994	8,221		20			8,221	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	995	(4)	23,372	25
26	Tower			1996	7,360		20			7,360	26
27	Door Open			1996	3,344		10			3,344	27
28	Landscaping			1997	1,500		20			1,500	28
29	Front Door Wiring			1997	1,396		20			1,396	29
30	Kelly Glass			1998	3,527		20			3,527	30
31	MTCO Phone System			1998	10,865	757	25	435	(322)	9,137	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:

1/1/2020

Ending:

12/31/2020

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	996	20	993	(3)	21,736	38
39	Sunroom	2000	86,294	1,920	45	1,920		39,357	39
40	Generator	2000	35,213	151	20		(151)	35,213	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,716		10			5,716	42
43	Nursing Office Addition	2001	759,951	16,707	45	16,707		325,877	43
44	Nurse Office Addition	2001	4,943	247	20	247		4,878	44
45	Blacktop	2001		603	20		(603)		45
46	Roof	2002	36,779		15			36,779	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		6,877	56
57	Service Door	2005	950		3			950	57
58	Blacktop Sealcoat	2005	3,373		5			3,373	58
59	Heat pump	2006	4,981		10			4,981	59
60	Heat pump	2006	4,260		10			4,260	60
61	Hall carpeting	2006	21,377		10			21,377	61
62	Concrete Sidewalk	2006		45	20		(45)		62
63	Alarm system	2007	3,304		5			3,304	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,335,455	\$ 158,719		\$ 157,514	\$ (1,205)	\$ 3,470,109	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:

1/1/2020

Ending:

12/31/2020

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		\$ 7,335,455	\$ 158,719		\$ 157,514	\$ (1,205)	\$ 3,470,109	1
2	Heat pump	2007	9,181		10			9,181	2
3	Hall 2 flooring	2007			10				3
4	Front signage	2008	15,386		10			15,386	4
5	Blacktop	2008	15,488	774	20	774		9,415	5
6	Heat Pump	2008	10,609		10			10,609	6
7	Rm flooring, wall & window covering, wood work, windows	2009	40,354	2,018	20	2,018		22,701	7
8	Energy management system controls	2009	19,344		10			19,344	8
9	Plumbing & sprinkler system	2009	21,157		10			21,157	9
10	Thermo systems	2009			10				10
11	Fencing	2009			10				11
12	Courtyard landscaping	2009	2,539		10			2,539	12
13	Window blinds for dining room	2009			5				13
14	Cable TV wiring	2009	33,168		8			33,168	14
15	Heat Pump	2010	16,061	856	10	938	82	16,061	15
16	Motion Detector & Electrical Fixtures	2010	9,081	454	10	454		9,081	16
17	Blacktop	2010	27,905	1,395	20	1,395		14,650	17
18	Schrepfer front door	2010	3,766	282	10	279	(3)	3,766	18
19	Fire system	2010			5				19
20	Heat Pump halls 1, 2, 3	2011	10,345	1,035	10	1,035		10,262	20
21	Health Center Hall1 Room Design/Drawings/Engineering	2011	13,665	1,367	10	1,367		13,553	21
22	Wall mounted shadow box & bulletin board	2011	2,528	253	10	253		2,508	22
23	Light fixtures, switches, outlets, breakers, wiring	2011	36,050	1,442	25	1,442		14,298	23
24	Toilets, sinks, faucets, piping, grab bar, lav top	2011	9,847	393	25	393		3,897	24
25	Corner & medicine cabinet, headboards	2011	9,053	905	10	905		8,973	25
26	Wall studs, wall board, paint, trim & guards	2011	6,120	245	25	245		2,429	26
27	Curtains w/track	2011	3,386	339	10	339		3,361	27
28	Chair rail & oak light boxes	2011	6,234	249	25	249		2,469	28
29	Window blinds & valances	2011	8,247	330	25	330		3,272	29
30	Wall protection 4'x8' sheets for resident rooms	2011	26,660	1,066	25	1,066		10,149	30
31	Health Center Hall1 Dining Rm Design/Drawings/Engineering	2011	124,070	2,757	45	2,757		26,248	31
32	Dining room flooring	2011	20,000	800	25	800		7,616	32
33	Hall 1 & 13 resident room flooring	2011	22,900	916	25	916		8,721	33
34	TOTAL (lines 1 thru 33)		\$ 7,858,599	\$ 176,595		\$ 175,469	\$ (1,126)	\$ 3,774,923	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:

1/1/2020

Ending:

12/31/2020

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		\$ 7,858,599	\$ 176,595		\$ 175,469	\$ (1,126)	\$ 3,774,923	1
2	Dining rm exhaust hood & fan	2011	5,408	216	25	216		2,057	2
3	Dining rm cabinetry & counter top	2011	4,700	470	10	470		4,292	3
4	Dining rm constr:walls-windows-doors,heat-a/c,plumbing,electrical	2011	480,326	8,567	45	10,674	2,107	102,577	4
5	Hall 2 fencing	2011		299	10		(299)		5
6	Sprinkler system improvements	2011	27,961	3,062	10	2,796	(266)	25,506	6
7	Two heat pumps	2011	4,991	499	10	499		4,751	7
8	Garbage Disposal	2011			5				8
9	Kitchen heat pump	2011	5,140	514	10	514		4,796	9
10	WI FI	2012	12,791		8			12,791	10
11	Sprinkler Heads	2012	12,531	1,253	10	1,253		11,277	11
12	Fire Supression Hall 1 & 2	2012	6,582	658	10	658		5,812	12
13	Hall 3 Remodeling - flooring, fixtures, electrical, wallpaper, paint	2012	132,957	7,201	25	5,318	(1,883)	46,978	13
14	Sprinkler system repair	2012	2,913		5			2,913	14
15	Heat Pumps	2012	4,655	466	10	466		3,868	15
16	Landscaping / Drainage work	2012	1,606	80	20	80		653	16
17	Front Entry Way redesign, Energy Efficient Double Door Entry, I	2013	37,567	1,779	25	1,503	(276)	11,646	17
18	Hall 4 Renovation- New flooring, rewiring, Heat Pumps, Lighting,	2013	100,470	5,470	25	4,019	(1,451)	30,141	18
19	Front Entry Way - Lobby flooring and molding	2013		77	25		(77)		19
20	Hall 4 Flooring	2013	11,545	1,155	10	1,155		8,662	20
21	Roof Replacement	2013	4,150	588	20	208	(380)	1,523	21
22	Nurses Station Flooring	2013	12,699	1,270	10	1,270		8,996	22
23	4 new Heat Pumps	2013	9,026	903	10	903		6,905	23
24	Blacktop Parking lot	2013	32,917	1,646	20	1,646		11,796	24
25	Roof Replacement -office, entrance, dining, laundry & maint room	2014	21,305	1,065	20	1,065		6,745	25
26	Hall 2 Renovations - Wall boards, painting and fixtures	2014	11,215	1,121	10	1,121		7,288	26
27	Hall 2 Renovations - electrical, walls and wall protections	2014	66,001	2,640	25	2,640		17,160	27
28	Install New Fire Alarm System	2015	126,696	5,075	25	5,068	(7)	32,642	28
29	Build New Entryway for Kitchen	2014	3,161	316	10	316		2,054	29
30	Dining Room Remodel- Flooring, Cabinets & Countertops	2014	4,265	1,254	10	427	(827)	2,774	30
31	Replace 2 heat pumps	2014	2,977	298	10	298		2,085	31
32	New Heat Pump/ A/C installed in ceiling	2014	3,849		5			3,849	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,009,003	\$ 224,537		\$ 220,052	\$ (4,485)	\$ 4,157,460	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:

1/1/2020

Ending:

12/31/2020

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		\$ 9,009,003	\$ 224,537		\$ 220,052	\$ (4,485)	\$ 4,157,460	1
2	New Carpeting - Hall 2	2015	27,962	2,796	10	2,796		16,776	2
3	Complete Fire Alarm System	2015	9,118	986	15	608	(378)	3,647	3
4	Electrical Wiring - 3 Rooms in Hall 2	2015		37	25		(37)		4
5	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	61,421	3,071	20	3,071		16,123	5
6	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	9,766	488	20	488		2,521	6
7	New Flooring - Dining Room	2015	3,362	336	10	336		1,680	7
8	Electrical Wiring - 3 Rooms in Hall 2	2015	2,807	281	10	281		1,662	8
9	Replace Heat Pumps	2015	3,696	370	10	370		2,220	9
10	Install New Elevator Pit	2015	4,180	418	10	418		2,264	10
11	Nurse Call System	2015	74,784	8,678	10	7,478	(1,200)	39,883	11
12	Walk In Cooler	2015	10,538	1,054	10	1,054		6,236	12
13	Wanderguard System	2015	20,800	880	10	2,080	1,200	12,307	13
14	Replace Heat Pumps	2015	7,413	741	10	741		3,890	14
15	New Cabinets and Countertops - Dining Room	2015	4,282	428	10	428		2,140	15
16	New Flooring - Assisted Dining Room	2016	5,637	564	10	564		2,751	16
17	Replace Bistro Door	2016		181	10		(181)		17
18	Replace Heat Pumps	2016	6,401	640	10	640		3,147	18
19	Patio - Maintenance Building	2016	8,000	400	20	400		1,767	19
20	Door Alarms	2016	4,959	496	10	496		2,356	20
21	Built-In Whirlpool Tub	2016	15,954	1,595	10	1,595		7,311	21
22	Roofing-Therapy Area	2016	11,739	587	20	587		2,593	22
23	Roofing - Hall 2	2016	11,127	556	20	556		2,270	23
24	Sump Pump in Basement	2016	2,884	288	10	288		1,224	24
25	Cabling for Network System	2016	16,000	1,600	10	1,600		6,667	25
26	Replace Bistro Door to Comply with Life Safety	2017	5,514	551	10	551		2,158	26
27	Piping & Plumbing Work to Bring to Code	2017	11,777	744	20	589	(155)	1,901	27
28	Replace Flooring in Therapy Entrance	2017	6,769	677	10	677		2,031	28
29	Replace Doors in Kitchen, Storage & Breakroom	2017	4,267	427	10	427		1,637	29
30	Install Emergency Power Breakers	2017	4,064	406	10	406		1,421	30
31	Walk-In Freezer	2017	8,970	897	10	897		2,915	31
32	300 Hospital Grade Recepticals,Outlets 20 amp	2018	3,618	362	10	362		995	32
33	Replace Kichen Hoods & Exhaust Fans	2018	7,493	749	10	749		1,998	33
34	TOTAL (lines 1 thru 33)		\$ 9,384,305	\$ 256,821		\$ 251,585	\$ (5,236)	\$ 4,313,951	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:

1/1/2020

Ending:

12/31/2020

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 12D, Carried Forward		\$ 9,384,305	\$ 256,821		\$ 251,585	\$ (5,236)	\$ 4,313,951	1
2	Replace Flooring/Electrical Wiring/Walls - Dietary Office	2018	2,613	131	20	131		349	2
3	Fire System Piping	2018		114			(114)		3
4	Fire Suppression Piping - Repair Leak	2018	2,922	292	10	292		608	4
5	Install New Camera System Throughout Facility	2018	12,601	1,260	10	1,260		2,520	5
6	Replace Ceiling Tiles Throughout Facility	2018	2,646	265	10	265		552	6
7	Cat 6 Wiring for TV's	2018		222			(222)		7
8	Replace Kitchen Hood	2018	2,506	251	10	251		669	8
9	New Heat Pump	2018	6,140	614	10	614		1,382	9
10	Sprinkler Replacement	2018		174			(174)		10
11	Work Site Preperation, Grading & Trellis for New Bistro	2019	92,879	4,644	20	4,644		8,127	11
12	New Turf/Grass for New Bistro	2019	14,440	722	20	722		1,083	12
13	Paint Service Hall	2019		131	10		(131)		13
14	Replace Windows Throughout Facility	2019	68,698	3,435	20	3,435		4,294	14
15	Replace Blinds Throughout Facility	2019	7,011	701	10	701		876	15
16	Transfer Switches - Electric	2019		154	10		(154)		16
17	Replace Gutters Throughout Facility	2019	3,610	181	20	181		316	17
18	Replace Central Nursing Counter Top	2019	4,851	485	10	485		809	18
19	New Bistro Shades,Cabinets, Exhaust Systems	2019	76,856	7,686	10	7,686		13,450	19
20	Installed New Security Cameras in Hall 2	2020	5,403	540	10	540		540	20
21	New Mural in Hall 2	2020		98			(98)		21
22	Replace Leaking Pipe in Attic/2 AMD Replacements	2020		198			(198)		22
23	New Sprinkler Heads in Canopies and Cooler/Freezer Area	2020	8,588	644	10	644		644	23
24	New Therapy Doors	2020		147			(147)		24
25	New Heat Exchange in Boiler 2 in Maintenance Area	2020	4,011	401	10	401		401	25
26	Sprinkler/Boiler Repair	2020		81			(81)		26
27	New Heat Pumps Installed in Bistro/Office/ & Other NH Areas	2020	16,847	983	10	983		983	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,716,927	\$ 281,375		\$ 274,820	\$ (6,555)	\$ 4,351,554	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	\$ 1,085,869	\$ 126,514	\$ 126,514	\$	Various	\$ 784,605	71
72	Current Year Purchases	72,795	6,354	5,929	(425)	3-10 Yrs	5,929	72
73	Fully Depreciated Assets	1,298,106	20,140	20,140		Various	1,298,106	73
74								74
75	TOTALS	\$ 2,456,770	\$ 153,008	\$ 152,583	\$ (425)		\$ 2,088,640	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	Patient Transport	2010 Transit Connect XLT	2015	18,623	\$ 2,173	\$ 2,172	\$ (1)	5	\$ 18,623	76
77										77
78										78
79										79
80	TOTALS			\$ 18,623	\$ 2,173	\$ 2,172	\$ (1)		\$ 18,623	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,280,370	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 436,556	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 429,575	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,981)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,458,817	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 7,679	92
93	(Wellness Center Design/		93
94	Heat Pumps)		94
95		\$ 7,679	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: _____
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: \$ 4,199 Description: Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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	\$	5,125	\$ 101,283	\$	5,125	\$ 101,283	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,324	55,297		1,324	55,297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		10,363	278,503	2,853	10,363	281,356	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				141,632		141,632	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Massage Therapist</u>	39(1),(2)	118	2,956			15	118	2,971	12
13	Other (specify): <u></u>									13
14	TOTAL			\$ 2,956	16,812	\$ 435,083	\$ 144,500	16,930	\$ 582,539	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	\$ 304,839	\$ 304,839	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 204,300)	706,698	706,698	3
4	Supply Inventory (priced at FIFO)	34,230	34,230	4
5	Short-Term Investments			5
6	Prepaid Insurance	111,064	111,064	6
7	Other Prepaid Expenses	37,595	37,595	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany Receivable	3,070,912	3,070,912	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,265,338	\$ 4,265,338	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,267,138	4,267,138	12
13	Land	88,050	88,050	13
14	Buildings, at Historical Cost	10,372,549	9,716,927	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,808,200	2,475,393	16
17	Accumulated Depreciation (book methods)	(6,281,127)	(6,458,817)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	22,316	22,316	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	7,679	7,679	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,284,805	\$ 10,118,686	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,550,143	\$ 14,384,024	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 825,155	\$ 825,155	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	329,051	329,051	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,779	31,779	31
32	Accrued Real Estate Taxes(Sch.IX-B)	235	235	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	43,935	43,935	36
37	Accrued 401K Plan	94,906	94,906	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,325,061	\$ 1,325,061	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	212,232	212,232	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	695,074	695,074	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 907,306	\$ 907,306	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,232,367	\$ 2,232,367	46
47	TOTAL EQUITY (page 18, line 24)	\$ 12,317,776	\$ 12,151,657	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,550,143	\$ 14,384,024	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,604,097	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)	\$ 11,604,096	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	713,680	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)	\$ 713,680	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)	\$ 12,317,776	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village

0033647

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 9,611,273	1
2	Discounts and Allowances for all Levels	(1,456,585)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,154,688	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,771	6
7	Oxygen	30,688	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 267,459	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,114,935	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,068	13
14	Non-Patient Meals	66,775	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,968	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	114,158	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,328,904	23
	D. Non-Operating Revenue		
24	Contributions	307,062	24
25	Interest and Other Investment Income***	273,245	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 580,307	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Service Fee Income	322,188	28
28a	See Pg 19A	14,949	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 337,137	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,668,495	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,630,010	31
32	Health Care	4,483,833	32
33	General Administration	2,289,872	33
	B. Capital Expense		
34	Ownership	449,525	34
	C. Ancillary Expense		
35	Special Cost Centers	847,931	35
36	Provider Participation Fee	253,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,954,815	40
41	Income before Income Taxes (line 30 minus line 40)**	713,680	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 713,680	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,377,895	44
45	Private Pay - Net Inpatient Revenue	5,774,666	45
46	Medicare - Net Inpatient Revenue	884,166	46
47	Other-(specify) Medicare C / Insurance	117,961	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,154,688	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 1/1/2020
Period End 12/31/2020

Schedule 19A

Amount

XVII. INCOME STATEMENT

Line 28a- Other Income

Van Income	11,538
Miscellaneous Income	440
Purchase Rebates	2,971
Total	<u>14,949</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	1,877	2,117	\$ 96,521	\$ 45.59	1
2	Assistant Director of Nursing	551	607	21,089	34.74	2
3	Registered Nurses	15,553	17,085	445,240	26.06	3
4	Licensed Practical Nurses	23,475	25,128	557,627	22.19	4
5	CNAs & Orderlies	103,014	111,733	1,564,364	14.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,243	1,437	22,696	15.79	8
9	Activity Director	1,933	2,167	50,068	23.10	9
10	Activity Assistants	18,227	19,704	265,800	13.49	10
11	Social Service Workers	4,966	5,488	108,016	19.68	11
12	Dietician	1,806	1,984	57,626	29.05	12
13	Food Service Supervisor	2,057	2,395	43,117	18.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,551	30,850	450,738	14.61	15
16	Dishwashers					16
17	Maintenance Workers	8,265	9,118	198,202	21.74	17
18	Housekeepers	13,692	14,681	202,066	13.76	18
19	Laundry	6,775	7,522	96,831	12.87	19
20	Administrator	1,920	2,080	110,003	52.89	20
21	Assistant Administrator					21
22	Other Administrative	1,904	2,080	147,616	70.97	22
23	Office Manager	3,956	4,170	147,707	35.42	23
24	Clerical	12,841	14,045	331,232	23.58	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>	17,163	18,994	522,753	27.52	33
34	TOTAL (lines 1 - 33)	269,769	293,385	\$ 5,439,312 *	\$ 18.54	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	302	\$ 14,808	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	33	2,226	L10, C3	37
38	Nurse Consultant	40	1,391	L10, C3	38
39	Pharmacist Consultant	Monthly	7,728	L10, C3	39
40	Physical Therapy Consultant	Monthly	16,077	L39, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	3,307	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) <u>MDS Consultant</u>	55	1,650	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	479	\$ 47,187		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	960	\$ 72,411	L10, C3	50
51	Licensed Practical Nurses	4,249	213,707	L10, C3	51
52	Certified Nurse Assistants/Aides	10,245	285,183	L10, C3	52
53	TOTAL (lines 50 - 52)	15,454	\$ 571,301		53

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village

Period Beginning 1/1/2020
Period End 12/31/2020

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	8,736	9,557	289,629	30.31
Ward Clerk	2,733	3,202	67,340	21.03
CNA Coordinator	1,905	2,140	51,312	23.98
Development	3,789	4,095	114,472	27.95
TOTAL	17,163	18,994	522,753	

STATE OF ILLINOIS

0033647

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

Facility Name & ID Number

Snyder Village

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keith Swartzentruber	Exec Director	0	\$ 147,616
Heather O'Brien	Administrator	0	110,003
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 257,619

B. Administrative - Other

Description	Amount
N/A	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
Matrixcare	Computer Software	\$ 26,233
CDS Office Technologies	Computer Service	17,144
Casamba	Computer Service	4,900
Kronos	Computer Service	3,131
Ability Network	Medicare Electronic Filing	4,378
Sage Software, Inc/Delphia	Payroll Software	21,486
E-Solutions	Computer Service	5,926
KS-Insight	Computer Service	163
Pentegra	401k Admin/Audit	22,450
Sweeney Conrad	401k Audit	12,625
Heinold - Banwart / Sikich	Accounting	13,515
See Pg 21A		14,592
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 146,543

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 187,984
Unemployment Compensation Insurance	
FICA Taxes	349,880
Employee Health Insurance	402,956
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	77,660
Employee Life/Disability	1,652
Employee Flex Time	73,998
Employee Physicals	3,336
Employee Appreciation	57,482
Employee Wellness	2,258
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,157,206

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	309
Health Care Worker Background Check (Indicate # of checks performed 83)	2,407
Patient Background Checks 200	2,000
Misc Dues & Licenses	614
LeadingAge Illinois	8,635
Relias Learning	2,266
Illinois Aging Services Network, LLC	2,248
Service Fee Income offset	(1,640)
Less: Public Relations Expense	(2,248)
Non-allowable advertising (	)
Yellow page advertising (	)
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,581

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,947
Entertainment Expense (	)
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,947

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule XIX C. Professional Fees

Vendor/Payee	Type	Amount
Templin Healthcare Accounting	Cost Report Preparation	5,562
Cost Management Services, LLC	HR Consultant	1,791
Insperty Business Services	HR Consultant	2,425
Provider Trust, Inc.	Healthcare Compliance	2,034
Insurance Program Managers Group	Mock Survey	1,750
Seagrove Consulting Group, LLC	Healthcare Compliance	231
Davis & Campbell L.L.C.	Legal	344
Johnson, Bunce & Noble, PC	Legal	455
	Total	14,592

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>8,635 Leading Age</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u> (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____ (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>3-10 Yrs</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>36,059</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u> (9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> 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. \$ <u>253,644</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>Yes: OP Therapy</u> 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. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>66,775</u> (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>50%</u> d. Have vehicle usage logs been maintained? <u>Yes</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u> Firm Name: <u>Sikich (Formerly Heinold-Banwart, Ltd.)</u> (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? <u>Yes</u> (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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.
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SEE ACCOUNTANTS' PREPARATION REPORT