FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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 (Number) Metamora (City) 61548 (Zip Code)

County: Woodford

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

HFS ID Number: [redacted]

Date of Initial License for Current Owners: 1988

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [x] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501 (c) 3

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 01/1/2010 to 12/31/2010 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) (Date)
(Print Name and Title) ROBERT REIN
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,325	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	105	TOTALS	105	38,325	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	365	347	4,168	4,880	8
9	SNF/PED					9
10	ICF	9,578	19,438		29,016	10
11	ICF/DD	-	-			11
12	SC	-	-			12
13	DD 16 OR LESS	-	-			13
14	TOTALS	9,943	19,785	4,168	33,896	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.44%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

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 [X] Date 1988 NO [ ]

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

YES [x] NO [ ] If YES, enter number of beds certified 105 and days of care provided 4,168

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	354,549		31,114	385,663		385,663		385,663			1
2	Food Purchase		267,668		267,668		267,668	(65,760)	201,908			2
3	Housekeeping	200,187	24,789	1,004	225,980		225,980	(7,668)	218,312			3
4	Laundry	77,397	14,219	70	91,686		91,686		91,686			4
5	Heat and Other Utilities			160,409	160,409		160,409	(37,017)	123,392			5
6	Maintenance	181,178	53,262	48,468	282,908		282,908	(4,233)	278,675			6
7	Other (specify):*											7
8	TOTAL General Services	813,311	359,938	241,065	1,414,314		1,414,314	(114,678)	1,299,636			8
	B. Health Care and Programs											
9	Medical Director			275	275		275		275			9
10	Nursing and Medical Records	2,749,819	99,126	91,373	2,940,318	(3,733)	2,936,585	(18,761)	2,917,824			10
10a	Therapy	20,757	3,140	366,582	390,479		390,479		390,479			10a
11	Activities	131,737	12,400	1,300	145,437		145,437		145,437			11
12	Social Services	79,470	1,139	2,033	82,642		82,642	(1,647)	80,995			12
13	CNA Training			591	591	6,402	6,993		6,993			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,981,783	115,805	462,154	3,559,742	2,669	3,562,411	(20,408)	3,542,003			16
	C. General Administration											
17	Administrative	185,474			185,474		185,474		185,474			17
18	Directors Fees											18
19	Professional Services			44,267	44,267	(135)	44,132		44,132			19
20	Dues, Fees, Subscriptions & Promotions			62,022	62,022	(3,179)	58,843	(39,499)	19,344			20
21	Clerical & General Office Expenses	305,967	29,024	74,846	409,837	(6,464)	403,373	(291,259)	112,114			21
22	Employee Benefits & Payroll Taxes			1,026,099	1,026,099	3,020	1,029,119		1,029,119			22
23	Inservice Training & Education			1,210	1,210		1,210		1,210			23
24	Travel and Seminar			6,559	6,559	6,758	13,317	(1,509)	11,808			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,091	69,091		69,091		69,091			26
27	Other (specify):*											27
28	TOTAL General Administration	491,441	29,024	1,284,094	1,804,559		1,804,559	(332,267)	1,472,292			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,286,535	504,767	1,987,313	6,778,615	2,669	6,781,284	(467,353)	6,313,931			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Snyder Village Health Center #0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			208,076	208,076		208,076	202	208,278			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,448	41,448		41,448	(4,889)	36,559			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,303	5,303		5,303		5,303			35
36	Other (specify):*											36
37	TOTAL Ownership			254,827	254,827		254,827	(4,687)	250,140			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,473	21,404	233,877	(2,669)	231,208		231,208			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		212,473	78,892	291,365	(2,669)	288,696		288,696			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,286,535	717,240	2,321,032	7,324,807		7,324,807	(472,040)	6,852,767			45

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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	(45,162)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	202	30.3		9
10	Interest and Other Investment Income	(4,889)	32.3		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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	-	43.3		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	(422,191)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (472,040)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ -		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (472,040)		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			x			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			x			44
45	Other-Attach Schedule		x			45
46	Other-Lab	x		2,669	10.3	46
47	TOTAL (C): (sum of lines 38-46)			$ 2,669		47

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 [x]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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					$	$		$ 0	25

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Commerce Bank		X	Building	$ 12,758.00	8/1/1987	$ 3,450,000	$ 644,840	Sep-26	5.071%	$ 34,027	1
2	CDAP Village Metamora		X	Building	4,340.00	Various	614,000	40,670	Various	3.750%	2,232	2
3					-							3
4					-							4
5					-							5
	Working Capital											
6	Gift Annuity		X	Building	510.00	Various	84,000	42,032	Various	6.750%	5,189	6
7					-					-		7
8					-				Less: Interest Income		(4,889)	8
9	TOTAL Facility Related				$ 17,608.00		$ 4,148,000	$ 727,543			$ 36,559	9
	B. Non-Facility Related*											
10										-		10
11										-		11
12										-		12
13										-		13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,148,000	$ 727,543			$ 36,559	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ 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.)

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:		
2005		8
2006		9
2007		10
2008		11
2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2009 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2009 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2009.

Please complete the Real Estate Tax Statement below and include it in the 2010 cost report along with a copy of your 2009 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyder Village Health Center 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 x 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [x] (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? [x] (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 - 135 Cottages @ 300,000 Ft2
Snyder Village Assisted Living - 41 Apartments @ 21,000 Ft2

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

1. Total Amount Incurred: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	155,422	1987	$ 43,000	1
2	Nursing Home		2001	1,300	2
3	TOTALS	155,422		$ 44,300	3

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61		1988	1988	$ 1,929,231	$ 42,872	45	$ 42,872	$	$ 964,618	4
5			1992	1992	127,495	2,833	45	2,833		52,649	5
6			1992	1992	33,830	1,353	25	1,353		24,581	6
7	18		1994	1994	600,872	13,353	45	13,353		224,773	7
8	26		1994	1994	1,256,597	27,924	45	27,924		449,114	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	45	20	45		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	70	20	70		1,336	15
16	Door Locks			1992	1,200	60	20	60		1,125	16
17	Patio			1992	1,219		10			1,219	17
18	Entrance Light			1993	619		10			619	18
19	Land Improvement			1994	25,546	1,277	20	1,277		20,540	19
20	Services Windows			1995	201,662	4,481	45	4,481		68,955	20
21	Landscaping			1995	13,848	692	20	692		8,900	21
22	Canopy			1995	1,102	55	20	55		830	22
23	Electrical Maintenance			1995	595	26	15	24	(2)	595	23
24	Door Locks			1995	505	20	15	17	(3)	505	24
25	Front Canopy			1996	44,945	999	45	999		13,469	25
26	Tower			1996	7,360	368	20	368		5,397	26
27	Door Open			1996	3,344		10			3,344	27
28	Landscaping			1997	1,500	75	20	75		1,013	28
29	Front Door Wiring			1997	1,396	70	20	70		967	29
30	Kelly Glass			1998	3,527	176	20	176		2,289	30
31	MTCO Phone System			1998	18,914	757	25	757		8,335	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	167	15	167		2,005	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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic Door Open	2000	$ 5,449	$	15	$ 363	$ 363	$ 3,812	37
38	Blacktop	2000	21,736	1,087	20	1,087		10,960	38
39	Sunroom	2000	86,410	1,920	45	1,920		20,157	39
40	Generator	2000	36,206	1,810	20	1,810		18,931	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,714	190	10	194	4	5,714	42
43	Nursing Office Addition	2001	751,810	16,707	45	16,707		158,807	43
44	Sunroom	2001	11,315	1,132	10	1,127	(5)	11,315	44
45	Tower	2001	5,640	564	10	564		5,405	45
46	Door	2001	2,545	255	10	255		2,337	46
47	Carpet	2001	3,529	353	10	353		3,236	47
48	Nurse Office Addition	2001	4,943	247	20	247		2,408	48
49	Blacktop	2001	12,054	603	20	603		5,528	49
50	Roof	2002	36,779	2,452	15	2,452		21,047	50
51	Hall 2 Room Alert	2002	5,015		5			5,015	51
52	Door, Tile, Drapes, Wall	2003	4,557	570	8	570		4,466	52
53	Door	2004	1,640		3			1,640	53
54	Roam Alert	2004	4,488		5			4,488	54
55	Carpet Hall 2	2004	856		5			856	55
56	Drapery	2004	2,335		5			2,335	56
57	Heat Pump	2005	2,165	217	10	217		1,248	57
58	Water Heater	2005	4,240	424	10	424		2,367	58
59	Therapy room door	2005	755	113	5	113		755	59
60	Hall 1 Nurses Station	2005	9,010	451	20	451		2,367	60
61	Service Door	2005	950		3			950	61
62	Blacktop Sealcoat	2005	3,373	506	5	505	(1)	3,373	62
63	Disposal unit	2006	2,221	222	10	222		1,091	63
64	Heat pump	2006	4,981	498	10	498		2,366	64
65	Air conditioning unit	2006	1,183	129	5	237	108	1,086	65
66	Heat pump	2006	4,260	426	10	426		1,845	66
67	Hall carpeting	2006	29,587	2,959	10	2,959		12,574	67
68	Sidewalk	2006	900	45	20	45		210	68
69	Alarm system	2007	3,304	661	5	661		2,642	69
70	TOTAL (lines 4 thru 69)		$ 5,397,347	$ 132,214		$ 132,678	$ 464	$ 2,226,689	70

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,397,347	$ 132,214		$ 132,678	$ 464	$ 2,226,689	1
2	Heat pump	2007	9,181	918	10	918		3,670	2
3	Hall 2 flooring	2007	27,466	2,747	10	2,747		9,385	3
4	Front signage	2008	15,386	1,539	10	1,539		3,462	4
5	Blacktop	2008	15,488	774	20	774		1,675	5
6	Heat Pump	2008	10,609	1,061	10	1,061		2,652	6
7	Rm flooring, wall & window covering, wood work, windows	2009	40,354	2,018	20	2,018		2,521	7
8	Energy management system controls	2009	19,344	1,935	10	1,934	(1)	3,863	8
9	Plumbing & sprinkler system	2009	21,157	2,294	10	2,116	(178)	4,046	9
10	Thermo systems	2009	1,808	181	10	181		226	10
11	Fencing	2009	909	91	10	91		129	11
12	Courtyard landscaping	2009	2,539	254	10	254		317	12
13	Window blinds for dining room	2009	1,329	266	5	266		488	13
14	Cable TV wiring	2009	33,168	4,146	8	4,146		4,828	14
15	Heat Pump	2010	16,061	750	10	669	(81)	669	15
16	Motion Detector & Electrical Fixtures	2010	9,081	454	10	455	1	455	16
17	Blacktop	2010	27,905	698	20	700	2	700	17
18	Schrepfer front door	2010	3,766	94	10	94		94	18
19	Fire system	2010	2,010	302	5	302		302	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	34

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	34

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	34

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	34

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	34

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,654,908	$ 152,736		$ 152,943	$ 207	$ 2,266,171	34

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 292,588	$ 47,519	$ 47,519	$	various	$ 210,046	71
72	Current Year Purchases	60,923	6,779	6,779		various	6,779	72
73	Fully Depreciated Assets	774,119				various	774,119	73
74								74
75	TOTALS	$ 1,127,630	$ 54,298	$ 54,298	$		$ 990,944	75

D. Vehicle Depreciation (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	Maintenance Use	99 Tate & Grimm Truck	1999	$ 22,259	$	$	$	5	$ 22,259	76
77	Nurse on Call	2002 Chevy Caviliar	2010	4,548	1,042	1,037	(5)	4	1,037	77
78	Resident Transportation	1996 & 1994 Van	1996	98,598				10	98,598	78
79	Patient Transport	2000 Ford Van	2002	29,900				10	29,900	79
80	TOTALS			$ 155,305	$ 1,042	$ 1,037	$ (5)		$ 151,794	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)	$ 6,982,143	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 208,076	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 208,278	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 202	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,408,909	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	Construction in Progress	$ 615,252	92
93			93
94			94
95		$ 615,252	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.

Facility Name & ID Number Snyder Village Health Center STATE OF ILLINOIS # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 [x] 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 [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 5,303 Description: Postage Meter $812; Copier $4,491
(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.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] 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	x
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
HOURS PER CNA	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		6,402		6,402
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		591		591
9	TOTALS	$	$ 6,993	$	$ 6,993
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,993			

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

(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.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$	475	$ 35,753	$	475	$ 35,753	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,518	104,471		1,518	104,471	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		552	40,680		552	40,680	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				142,826	142,826		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Exceptional Care	39.2								12
13	Other (specify): Medical Supplies	39.2					69,646	69,646		13
14	TOTAL			$	2,545	$ 180,904	$ 212,472	2,545	$ 393,376	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.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 651,867	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (46,140))	1,117,144		3
4	Supply Inventory (priced at FIFO)	24,498		4
5	Short-Term Investments	113,532		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	147,254		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 2,008,155	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,335		12
13	Land	44,300		13
14	Buildings, at Historical Cost	5,266,556		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,663,099		16
17	Accumulated Depreciation (book methods)	(3,307,367)		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):	702,486		22
23	Other(specify): Construction in Progress	615,252		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 4,985,661	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 6,993,816	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 170,100	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,896		30
31	Accrued Taxes Payable (excluding real estate taxes)			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	Employee Benefits Payable	208,089		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 607,085	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	727,543		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)	$ 727,543	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 1,334,628	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 5,659,188	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 6,993,816	$	48

*(See instructions.)

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	Balance at Beginning of Year, as Previously Reported	$ 5,012,177	1	
2	Restatements (describe):		2	
3			3	
4	Prior period adjustments	(120,043)	4	
5			5	
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 4,892,134	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	767,054	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)	$ 767,054	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)	$ 5,659,188	24	*

* This must agree with page 17, line 47.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,865,907	1
2	Discounts and Allowances for all Levels	(1,435,536)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 5,430,371	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,174,337	6
7	Oxygen	43,595	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 1,217,932	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	6,600	12
13	Barber and Beauty Care	4,249	13
14	Non-Patient Meals	45,162	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	309,659	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,082	20
21	Other Medical Services	147,716	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 537,468	23
	D. Non-Operating Revenue		
24	Contributions	483,229	24
25	Interest and Other Investment Income***	91,485	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 574,714	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	288,413	28
28a	Other Income	42,963	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 331,376	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 8,091,861	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,414,314	31
32	Health Care	3,559,742	32
33	General Administration	1,804,559	33
	B. Capital Expense		
34	Ownership	254,827	34
	C. Ancillary Expense		
35	Special Cost Centers	233,877	35
36	Provider Participation Fee	57,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 7,324,807	40
41	Income before Income Taxes (line 30 minus line 40)**	767,054	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 767,054	43

* 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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,836	2,080	$ 75,134	$ 36.12	1
2	Assistant Director of Nursing	1,744	1,872	57,386	30.65	2
3	Registered Nurses	24,326	26,025	554,890	21.32	3
4	Licensed Practical Nurses	17,804	18,990	531,732	28	4
5	CNAs & Orderlies	94,885	103,425	1,432,210	13.85	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	1,504	1,577	20,757	13.16	8
9	Activity Director	1,609	1,782	29,646	16.64	9
10	Activity Assistants	8,731	9,375	102,091	10.89	10
11	Social Service Workers	4,713	5,117	79,470	15.53	11
12	Dietician	2,926	3,238	59,559	18.39	12
13	Food Service Supervisor	1,840	2,054	30,870	15.03	13
14	Head Cook	-	-	-		14
15	Cook Helpers/Assistants	23,543	25,257	264,120	10.46	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	10,169	11,055	181,178	16.39	17
18	Housekeepers	15,056	16,558	200,187	12.09	18
19	Laundry	6,776	7,520	77,397	10.29	19
20	Administrator	1,928	2,080	81,000	38.94	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	1,816	2,080	104,474	50.23	22
23	Office Manager	1,875	2,066	56,431	27.31	23
24	Clerical	10,148	11,243	163,834	14.57	24
25	Vocational Instruction	273	273	6,402	23.45	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	3,992	4,378	54,855	12.53	31
32	Other Health Care(specify)	-	-	-		32
33	Other(specify)	1,719	1,872	37,210	19.88	33
34	TOTAL (lines 1 - 33)	239,213	259,917	$ 4,200,833 *	$ 16.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	180	$ 9,243	1.3	35
36	Medical Director	3	275	9.3	36
37	Medical Records Consultant	35	2,453	10.3	37
38	Nurse Consultant	-	-		38
39	Pharmacist Consultant	72	5,371	10.3	39
40	Physical Therapy Consultant	32	2,049	10a.3	40
41	Occupational Therapy Consultant	51	3,270	10a.3	41
42	Respiratory Therapy Consultant	-	-		42
43	Speech Therapy Consultant	46	2,927	10a.3	43
44	Activity Consultant	19	1,300	11.3	44
45	Social Service Consultant	22	1,008	12.3	45
46	Other(specify)	-			46
47					47
48					48
49	TOTAL (lines 35 - 48)	458	$ 27,896		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	446	$ 16,655	10.3	50
51	Licensed Practical Nurses	1,441	50,359	10.3	51
52	Certified Nurse Assistants/Aides	825	14,501	10.3	52
53	TOTAL (lines 50 - 52)	2,712	$ 81,514		53

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tom Becker	ADMINISTRATOR		$ 81,000
Keith Swartzentruber	Excecutive Director		104,474
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 185,474

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Heinold Banwart LTD	Accounting	$ 18,089
Robert Rein CPA	Accounting	5,250
Johnson, Bunce & Noble	Legal	378
Adaptsoft, Inc.	Computer	11,475
Reclassification		135
Designware Systems, Inc.	Computer	8,940
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 44,267

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 167,820
Unemployment Compensation Insurance	14,075
FICA Taxes	308,280
Employee Health Insurance	362,446
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	139,357
Employee Life/Disability	2,630
Employee Flex Time	12,968
Hep B & Employee Physicals	3,020
Employee Appreciation	15,661
Other Benefits	2,862
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,029,119

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	46,403
Health Care Worker Background Check	752
(Indicate # of checks performed 75.2)	
Patient Background Checks 115	1,150
Life Services Network of IL	5,043
Central IL Quality Alliance	723
Dues & Licenses	1,974
Subscription	808
Less: Public Relations Expense	( )
Non-allowable advertising	(34,957)
Yellow page advertising	(4,542)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,344

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (1,509)
In-State Travel	4,251
Seminar Expense	9,066
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,808

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$ $	$	$	$	$	$	$	$	

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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. Life Services Network of IL 5,043

(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? yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? 105

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ $ 47,899 Line 10.2

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO no 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. $ 57,488
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 benefits on Schedule V. $ Has any meal income been offset against related costs? yes Indicate the amount. $ 45,162

(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. $
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? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.