FOR BHF USE

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

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

I.

IDPH License ID Number: 0033647

Facility Name: Snyder Village Health Center

Address: 1200 East Partridge (Number) Metamora (City) 61548 (Zip Code)

County: Woodford

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

HFS ID Number:

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 01/1/2011 to 12/31/2011 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)
(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: 01/1/2011 Ending: 12/31/2011

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 2/3/11

	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)	104	37,993	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	104	37,993	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	485	4,187	5,037	8
9	SNF/PED					9
10	ICF	10,917	17,845		28,762	10
11	ICF/DD	-	-			11
12	SC	-	-			12
13	DD 16 OR LESS	-	-			13
14	TOTALS	11,282	18,330	4,187	33,799	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.8896

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 104 and days of care provided 4,187

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: 12/31/2011 Fiscal Year: 12/31/2011

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

STATE OF ILLINOIS

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	376,307	-	28,103	404,410	-	404,410	-	404,410			1
2	Food Purchase		301,718		301,718	-	301,718	(52,639)	249,079			2
3	Housekeeping	204,551	25,829	657	231,037	-	231,037	(8,065)	222,972			3
4	Laundry	82,368	14,210	-	96,578	-	96,578	-	96,578			4
5	Heat and Other Utilities			134,402	134,402	-	134,402	(46,856)	87,546			5
6	Maintenance	201,608	41,593	43,521	286,722	-	286,722	(4,109)	282,613			6
7	Other (specify):*	-	-	-	-	-	-	-	-			7
8	TOTAL General Services	864,834	383,350	206,683	1,454,867	-	1,454,867	(111,669)	1,343,198			8
	B. Health Care and Programs											
9	Medical Director			450	450	-	450		450			9
10	Nursing and Medical Records	2,780,771	102,187	51,509	2,934,467	-	2,934,467	(16,401)	2,918,066			10
10a	Therapy	29,607	3,216	379,809	412,632	-	412,632		412,632			10a
11	Activities	143,477	10,489	2,545	156,511	-	156,511		156,511			11
12	Social Services	81,437	787	5,790	88,014	-	88,014	(1,102)	86,912			12
13	CNA Training				-	-	-		-			13
14	Program Transportation				-	-	-		-			14
15	Other (specify):*				-	-	-		-			15
16	TOTAL Health Care and Programs	3,035,292	116,679	440,103	3,592,074	-	3,592,074	(17,503)	3,574,571			16
	C. General Administration											
17	Administrative	193,651	-	-	193,651	-	193,651	-	193,651			17
18	Directors Fees			-	-	-	-	-	-			18
19	Professional Services			60,131	60,131	(183)	59,948	-	59,948			19
20	Dues, Fees, Subscriptions & Promotions			90,546	90,546	(6,155)	84,391	(65,848)	18,543			20
21	Clerical & General Office Expenses	324,155	25,324	96,029	445,508	(6,711)	438,797	(330,679)	108,118			21
22	Employee Benefits & Payroll Taxes			955,416	955,416	6,143	961,559	-	961,559			22
23	Inservice Training & Education			4,437	4,437	-	4,437	-	4,437			23
24	Travel and Seminar			5,463	5,463	6,906	12,369	-	12,369			24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-			25
26	Insurance-Prop.Liab.Malpractice			55,968	55,968	-	55,968	-	55,968			26
27	Other (specify):*		-	-	-	-	-	-	-			27
28	TOTAL General Administration	517,806	25,324	1,267,990	1,811,120	-	1,811,120	(396,527)	1,414,593			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,417,932	525,353	1,914,776	6,858,061	-	6,858,061	(525,699)	6,332,362			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: 01/1/2011 Ending: 12/31/2011

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			241,723	241,723	-	241,723	(10,740)	230,983			30
31	Amortization of Pre-Op. & Org.			-	-	-	-	-	-			31
32	Interest			31,098	31,098	-	31,098	(2,591)	28,507			32
33	Real Estate Taxes			-	-	-	-	-	-			33
34	Rent-Facility & Grounds			-	-	-	-	-	-			34
35	Rent-Equipment & Vehicles			9,135	9,135	-	9,135	-	9,135			35
36	Other (specify):*			-	-	-	-	-	-			36
37	TOTAL Ownership			281,956	281,956	-	281,956	(13,331)	268,625			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-	-	-	-	-			38
39	Ancillary Service Centers	-	209,289	15,150	224,439	-	224,439	-	224,439			39
40	Barber and Beauty Shops	-	-	-	-	-	-	-	-			40
41	Coffee and Gift Shops	-	-	-	-	-	-	-	-			41
42	Provider Participation Fee	-	-	87,290	87,290	-	87,290	-	87,290			42
43	Other (specify):*	-	-	-	-	-	-	-	-			43
44	TOTAL Special Cost Centers	-	209,289	102,440	311,729	-	311,729	-	311,729			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,417,932	734,642	2,299,172	7,451,746	-	7,451,746	(539,030)	6,912,716			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: 01/1/2011 Ending: 12/31/2011

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	(35,642)	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	(10,740)	30.3		9
10	Interest and Other Investment Income	(2,591)	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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,651)	20.3		28
29	Other-Attach Schedule	(486,406)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (539,030)		$	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))	$ (539,030)		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-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2011 Ending: 12/31/2011

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

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: 01/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	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: 01/1/2011 Ending: 12/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/1/2011 Ending: 12/31/2011

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	8/1/87	$ 3,450,000	$ 506,873	Sep-26	0.0507	$ 23,613	1
2	CDAP Village Metamora		X	Building	4,340	Various	614,000	33,041	Various	0.0375	1,860	2
3					-							3
4					-							4
5					-							5
	Working Capital											
6	Gift Annuity		X	Building	510	Various	84,000	38,842	Various	0.0675	5,625	6
7					-							7
8					-				Less: Interest Income		(2,591)	8
9	TOTAL Facility Related				$17,608.00		$ 4,148,000	$ 578,757			$ 28,507	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	$ 578,757			$ 28,507	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: 01/1/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		
2006		8
2007		9
2008		10
2009		11
2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2010 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 2010 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2010.

Please complete the Real Estate Tax Statement below and include it in the 2011 cost report along with a copy of your 2010 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.

2010 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2011 Ending: 12/31/2011

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: 01/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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	$	$ 1,007,490	4
5			1992	1992	127,495	2,833	45	2,833		55,482	5
6			1992	1992	33,830	1,353	25	1,353		25,934	6
7	18		1994	1994	600,872	13,353	45	13,353		238,126	7
8	26		1994	1994	1,256,597	27,924	45	27,924		477,038	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	64	20	64		1,400	15
16	Door Locks			1992	1,200	60	20	60		1,185	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		21,817	19
20	Services Windows			1995	201,662	4,481	45	4,481		73,436	20
21	Landscaping			1995	13,848	692	20	692		9,592	21
22	Canopy			1995	1,102	55	20	55		885	22
23	Electrical Maintenance			1995	595		15			595	23
24	Door Locks			1995	505		15			505	24
25	Front Canopy			1996	44,945	999	45	999		14,468	25
26	Tower			1996	7,360	368	20	368		5,765	26
27	Door Open			1996	3,344		10			3,344	27
28	Landscaping			1997	1,500	75	20	75		1,088	28
29	Front Door Wiring			1997	1,396	70	20	70		1,037	29
30	Kelly Glass			1998	3,527	176	20	176		2,465	30
31	MTCO Phone System			1998	18,914	757	25	757		9,092	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		2,172	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: 01/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 4,175	37
38	Blacktop	2000	21,736	1,087	20	1,087		12,047	38
39	Sunroom	2000	86,410	1,920	45	1,920		22,077	39
40	Generator	2000	36,206	1,810	20	1,810		20,741	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,714		10			5,714	42
43	Nursing Office Addition	2001	751,810	16,707	45	16,707		175,514	43
44	Sunroom	2001	11,315		10			11,315	44
45	Tower	2001	5,640	235	10	235		5,640	45
46	Door	2001	2,545	212	10	208	(4)	2,545	46
47	Carpet	2001	3,529	294	10	293	(1)	3,529	47
48	Nurse Office Addition	2001	4,943	247	20	247		2,655	48
49	Blacktop	2001	12,054	603	20	603		6,131	49
50	Roof	2002	36,779	2,452	15	2,452		23,499	50
51	Hall 2 Room Alert	2002	5,015		5			5,015	51
52	Door, Tile, Drapes, Wall	2003	4,557	95	8	91	(4)	4,557	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		1,465	57
58	Water Heater	2005	4,240	424	10	424		2,791	58
59	Therapy room door	2005	755		5			755	59
60	Hall 1 Nurses Station	2005	9,010	451	20	451		2,818	60
61	Service Door	2005	950		3			950	61
62	Blacktop Sealcoat	2005	3,373		5			3,373	62
63	Disposal unit	2006	2,221	222	10	222		1,313	63
64	Heat pump	2006	4,981	498	10	498		2,864	64
65	Air conditioning unit	2006	1,183	90	5	97	7	1,183	65
66	Heat pump	2006	4,260	426	10	426		2,271	66
67	Hall carpeting	2006	29,587	2,959	10	2,959		15,533	67
68	Sidewalk	2006	900	45	20	45		255	68
69	Alarm system	2007	3,304	661	5	661		3,303	69
70	TOTAL (lines 4 thru 69)		$ 5,397,347	$ 129,231		$ 129,592	$ 361	$ 2,356,281	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: 01/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 129,231		$ 129,592	$ 361	$ 2,356,281	1
2	Heat pump	2007	9,181	918	10	918		4,588	2
3	Hall 2 flooring	2007	27,466	2,747	10	2,747		12,132	3
4	Front signage	2008	15,386	1,539	10	1,539		5,001	4
5	Blacktop	2008	15,488	774	20	774		2,449	5
6	Heat Pump	2008	10,609	1,061	10	1,061		3,713	6
7	Rm flooring, wall & window covering, wood work, windows	2009	40,354	2,018	20	2,018		4,539	7
8	Energy management system controls	2009	19,344	1,935	10	1,934	(1)	5,797	8
9	Plumbing & sprinkler system	2009	21,157	2,294	10	2,116	(178)	6,162	9
10	Thermo systems	2009	1,808	181	10	181		407	10
11	Fencing	2009	909	91	10	91		220	11
12	Courtyard landscaping	2009	2,539	254	10	254		571	12
13	Window blinds for dining room	2009	1,329	266	5	266		754	13
14	Cable TV wiring	2009	33,168	4,146	8	4,146		8,974	14
15	Heat Pump	2010	16,061	1,607	10	1,606	(1)	2,275	15
16	Motion Detector & Electrical Fixtures	2010	9,081	908	10	908		1,363	16
17	Blacktop	2010	27,905	1,395	20	1,395		2,095	17
18	Schrepfer front door	2010	3,766	377	10	377		471	18
19	Fire system	2010	2,010	402	5	402		704	19
20	Heat Pump halls 1, 2, 3	2011	10,345	1,141	10	947	(194)	947	20
21	Health Center Hall1 Room Design/Drawings/Engineering	2011	13,665		10	1,250	1,250	1,250	21
22	Wall mounted shadow box & bulletin board	2011	2,528		10	231	231	231	22
23	Light fixtures, switches, outlets, breakers, wiring	2011	36,050		25	1,320	1,320	1,320	23
24	Toilets, sinks, faucets, piping, grab bar, lav top	2011	9,847		25	360	360	360	24
25	Corner & medicine cabinet, headboards	2011	9,053		10	828	828	828	25
26	Wall studs, wall board, paint, trim & guards	2011	6,120		25	224	224	224	26
27	Curtains w/track	2011	3,386		10	310	310	310	27
28	Chair rail & oak light boxes	2011	6,234		25	228	228	228	28
29	Window blinds & valances	2011	8,247		25	302	302	302	29
30	Wall protection 4'x8' sheets for resident rooms	2011	26,660		25	555	555	555	30
31	Health Center Hall1 Dining Rm Design/Drawings/Engineering	2011	124,070	10,870	45	1,435	(9,435)	1,435	31
32	Dining room flooring	2011	20,000	1,728	25	416	(1,312)	416	32
33	Hall 1 & 13 resident room flooring	2011	22,900	3,870	25	477	(3,393)	477	33
34	TOTAL (lines 1 thru 33)		$ 5,954,013	$ 169,753		$ 161,208	$ (8,545)	$ 2,427,379	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: 01/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 5,954,013	$ 169,753		$ 161,208	$ (8,545)	$ 2,427,379	1
2	Dining rm exhaust hood & fan	2011	5,408		25	113	113	113	2
3	Dining rm cabinetry & counter top	2011	7,688		10	400	400	400	3
4	Dining rm construction:walls-windows-doors,heat-a/c,plumbing,electri	2011	480,326	7,872	45	5,556	(2,316)	5,556	4
5	Hall 2 fencing	2011	2,996	175	10	163	(12)	163	5
6	Sprinkler system improvements	2011	30,617	1,276	25	638	(638)	638	6
7	Two heat pumps	2011	4,991		10	260	260	260	7
8	Garbage Disposal	2011	2,684	179	5	178	(1)	178	8
9	Kitchen heat pump	2011	5,140	171	10	170	(1)	170	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,493,863	$ 179,426		$ 168,686	$ (10,740)	$ 2,434,857	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: 01/1/2011 Ending: 12/31/2011

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	$ 364,165	$ 52,649	$ 52,649	$	various	$ 207,589	71
72	Current Year Purchases	75,132	8,511	8,511		various	8,511	72
73	Fully Depreciated Assets	836,004				various	836,004	73
74								74
75	TOTALS	$ 1,275,301	$ 61,160	$ 61,160	$		$ 1,052,104	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	Maintenance Use	99 Tate & Grimm Truck	1999	$ 22,259	$	$	$	5	$ 22,259	76
77	Nurse on Call	2002 Chevy Caviliar	2010	4,548	1,137	1,137		4	2,174	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	$ 1,137	$ 1,137	$		$ 152,931	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)	$ 7,968,769	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 241,723	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 230,983	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,740)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,639,892	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	$ 234,561	92
93			93
94			94
95		$ 234,561	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 # 0033647 Report Period Beginning: 01/1/2011 Ending: 12/31/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 9,135 Description: Postage Meter $508; Copier $8,627
(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: 01/1/2011 Ending: 12/31/2011

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
[ ] YES
[x] 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.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2011 Ending: 12/31/2011

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	$	574	$ 36,716	$	574	$ 36,716	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,193	76,351		1,193	76,351	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		695	44,471		695	44,471	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				150,338		150,338	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					58,951		58,951	13
14	TOTAL			$	2,462	$ 157,538	$ 209,289	2,462	$ 366,827	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: 01/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 481,500	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,920))	1,140,402		3
4	Supply Inventory (priced at FIFO)	30,336		4
5	Short-Term Investments	(12,992)		5
6	Prepaid Insurance	129,991		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 1,769,237	$	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	5,873,435		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,824,067		16
17	Accumulated Depreciation (book methods)	(3,298,366)		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):	793,937		22
23	Other(specify): Construction in Progress	234,561		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 5,473,269	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 7,242,506	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 214,044	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	248,518		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,300		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	171,917		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 664,779	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	578,757		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)	$ 578,757	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 1,243,536	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 5,998,970	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 7,242,506	$	48

*(See instructions.)

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 01/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	Balance at Beginning of Year, as Previously Reported	$ 5,659,188	1	
2	Restatements (describe):		2	
3			3	
4	Prior period adjustments	(4,096)	4	
5			5	
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 5,655,092	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	343,878	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)	$ 343,878	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)	$ 5,998,970	24	*

* This must agree with page 17, line 47.

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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	$ 6,991,127	1
2	Discounts and Allowances for all Levels	(1,608,851)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 5,382,276	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,109,352	6
7	Oxygen	41,050	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 1,150,402	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	14,883	11
12	Gift and Coffee Shop	5,191	12
13	Barber and Beauty Care	3,793	13
14	Non-Patient Meals	61,229	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	332,282	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,394	20
21	Other Medical Services	130,793	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 569,565	23
	D. Non-Operating Revenue		
24	Contributions	344,396	24
25	Interest and Other Investment Income***	2,591	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 346,987	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	325,654	28
28a	Other Income	20,740	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 346,394	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 7,795,624	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,454,867	31
32	Health Care	3,592,074	32
33	General Administration	1,811,120	33
	B. Capital Expense		
34	Ownership	281,956	34
	C. Ancillary Expense		
35	Special Cost Centers	224,439	35
36	Provider Participation Fee	87,290	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 7,451,746	40
41	Income before Income Taxes (line 30 minus line 40)**	343,878	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 343,878	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	1,864	2,080	$ 77,013	$ 37.03	1
2	Assistant Director of Nursing	1,762	1,856	56,595	30.49	2
3	Registered Nurses	21,780	23,558	622,776	26.44	3
4	Licensed Practical Nurses	22,729	24,519	531,540	21.68	4
5	CNAs & Orderlies	96,034	103,874	1,396,930	13.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,755	1,845	29,607	16.05	8
9	Activity Director	1,932	2,080	35,476	17.06	9
10	Activity Assistants	9,037	9,678	108,001	11.16	10
11	Social Service Workers	4,672	5,224	81,437	15.59	11
12	Dietician	3,293	3,650	68,861	18.87	12
13	Food Service Supervisor	1,814	2,052	31,847	15.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,783	27,140	275,599	10.15	15
16	Dishwashers					16
17	Maintenance Workers	10,344	10,998	201,608	18.33	17
18	Housekeepers	15,494	16,919	204,551	12.09	18
19	Laundry	7,168	7,731	82,368	10.65	19
20	Administrator	1,880	2,080	84,801	40.77	20
21	Assistant Administrator					21
22	Other Administrative	1,848	2,080	108,850	52.33	22
23	Office Manager	1,916	2,080	58,636	28.19	23
24	Clerical	10,357	11,443	170,042	14.86	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	3,998	4,271	57,776	13.53	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	1,748	1,872	38,141	20.37	33
34	TOTAL (lines 1 - 33)	247,208	267,030	$ 4,322,455 *	$ 16.19	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	130	$ 7,515	1.3	35
36	Medical Director	5	450	9.3	36
37	Medical Records Consultant	34	2,403	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	82	6,154	10.3	39
40	Physical Therapy Consultant	134	8,587	10a.3	40
41	Occupational Therapy Consultant	30	1,951	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16	1,005	10a.3	43
44	Activity Consultant	36	2,475	11.3	44
45	Social Service Consultant	18	958	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	485	$ 31,497		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10.3	50
51	Licensed Practical Nurses	1,070	33,880	10.3	51
52	Certified Nurse Assistants/Aides	370	6,277	10.3	52
53	TOTAL (lines 50 - 52)	1,440	$ 40,157		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Scc Schedule			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 193,651

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
		$
Scc Schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 60,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 180,216
Unemployment Compensation Insurance	27,450
FICA Taxes	321,071
Employee Health Insurance	292,864
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	93,745
Employee Life/Disability	2,685
Employee Flex Time	19,385
Hep B & Employee Physicals	6,143
Employee Appreciation	16,489
Other Benefits	1,512
Rounding	(1)
TOTAL (agree to Schedule V, line 22, col.8)	$ 961,559

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	72,451
Health Care Worker Background Check	1,568
(Indicate # of checks performed 56)	
Patient Background Checks 123	1,230
Life Services Network of IL	5,419
Central IL Quality Alliance	518
Dues & Licenses	1,101
Subscription	114
Less: Public Relations Expense	( )
Non-allowable advertising	(62,197)
Yellow page advertising	(3,651)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,543

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,369
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,369

**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													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 5,419

(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?

(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?

(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? 6

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 44,516 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 x NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 87,290
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. $ 35,642

(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.