FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0005363

Facility Name: Snyders Vaughn Haven

Address: 135 South Morgan St (Number) Rushville (City) 62681 (Zip Code)

County: Schuyler

Telephone Number: (217) 322-3420 **Fax #** (217) 322-6537

HFS ID Number:

Date of Initial License for Current Owners: 1966

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** 630-361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/14 to 12/31/14 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) David Grate
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	211	213	2,126	2,550	8
9	SNF/PED					9
10	ICF	10,198	6,984		17,182	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,409	7,197	2,126	19,732	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.61%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1966

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1992 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 2,126

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

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

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

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	185,786	37,245		223,031		223,031		223,031			1
2	Food Purchase		135,366		135,366		135,366	(1,485)	133,881			2
3	Housekeeping	71,731			71,731		71,731		71,731			3
4	Laundry	55,157	6,388		61,545		61,545		61,545			4
5	Heat and Other Utilities			68,299	68,299		68,299		68,299			5
6	Maintenance	62,256	21,759	34,712	118,727		118,727		118,727			6
7	Other (specify):* Waste Removal			7,258	7,258		7,258		7,258			7
8	TOTAL General Services	374,930	200,758	110,269	685,957		685,957	(1,485)	684,472			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	924,418	46,993	1,767	973,178		973,178		973,178			10
10a	Therapy		46	300,631	300,677		300,677		300,677			10a
11	Activities	19,135	1,722	990	21,847		21,847		21,847			11
12	Social Services	38,145		3,840	41,985		41,985		41,985			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	981,698	48,761	309,028	1,339,487		1,339,487		1,339,487			16
	C. General Administration											
17	Administrative	46,440		15,800	62,240		62,240		62,240			17
18	Directors Fees											18
19	Professional Services			95,561	95,561		95,561		95,561			19
20	Dues, Fees, Subscriptions & Promotions			5,610	5,610		5,610	(1,224)	4,386			20
21	Clerical & General Office Expenses	57,780	5,192	33,975	96,947		96,947	(145)	96,802			21
22	Employee Benefits & Payroll Taxes			178,612	178,612		178,612		178,612			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,724	1,724		1,724		1,724			24
25	Other Admin. Staff Transportation			2,909	2,909		2,909		2,909			25
26	Insurance-Prop.Liab.Malpractice			58,847	58,847		58,847		58,847			26
27	Other (specify):*											27
28	TOTAL General Administration	104,220	5,192	393,038	502,450		502,450	(1,369)	501,081			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,460,848	254,711	812,335	2,527,894		2,527,894	(2,854)	2,525,040			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 Snyders Vaughn Haven #0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,200	13,200		13,200	58,058	71,258			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,170	1,170		1,170	57,605	58,775			32
33	Real Estate Taxes			42,043	42,043		42,043		42,043			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			9,203	9,203		9,203		9,203			35
36	Other (specify):*											36
37	TOTAL Ownership			209,616	209,616		209,616	(28,337)	181,279			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,995		71,995		71,995		71,995			39
40	Barber and Beauty Shops			1,280	1,280		1,280		1,280			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			144,195	144,195		144,195		144,195			42
43	Other (specify):* Non-allowable Costs			689,402	689,402		689,402	(675,598)	13,804			43
44	TOTAL Special Cost Centers		71,995	834,877	906,872		906,872	(675,598)	231,274			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,460,848	326,706	1,856,828	3,644,382		3,644,382	(706,789)	2,937,593			45

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

Snyders Vaughn Haven

Period Beginning **1/1/14**
Period End **12/31/14**

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			13,804	13,804		13,804		13,804			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses			675,598	675,598		675,598	(675,598)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	689,402	689,402	0	689,402	(675,598)	13,804			

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	(1,485)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,979)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,146	30		9
10	Interest and Other Investment Income	(1,484)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,204)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(29,322)	43		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	(574,146)	43		24
25	Fund Raising, Advertising and Promotional	(12,942)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(32,001)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(23,373)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (653,790)		$	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)	(52,999)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (52,999)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (706,789)		37

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

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

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

Snyders Vaughn Haven

ID# 0005363

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income	$ (145)	21	1
2	Disallow PAC Dues	(1,224)	20	2
3	Disallow Loss on Sale of Investments	(22,004)	43	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23,373)		49

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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
Marcia Dianne Snyder	50	None		Snyder Properties	Rushville, IL	Lessor
Vaughn I. Snyder	50					

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. [X] 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)	
1	V	30	Depreciation	$	Snyder Properties	100.00%	$ 31,912	$ 31,912	1
2	V	32	Interest		Snyder Properties	100.00%	59,089	59,089	2
3	V	34	Rent	144,000	Snyder Properties	100.00%		(144,000)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 144,000			$ 91,001	$ * (52,999)	14

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

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	John R. Snyder	Administrator	Administrator	0.00	N/A	50	100.00	Salary	$ 5,400	L17, C1	1
2	Marcia Dianne Snyder	DON	Nursing Admin.	50.00	N/A	50	100.00	Salary	28,642	L10, C1	2
3	Aaron Snyder	Clerical	Clerical	0.00	N/A	40	100.00	Salary	18,896	L21, C1	3
4	Gregg Snyder	Maintenance	Maintenance	0.00	N/A	40	100.00	Salary	20,358	L6, C1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 73,296		13

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

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

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	First Mid Illinois		X	Mortgage	$8,249.45	11/2012	$ 1,250,000	$ 1,170,340	11/2032	0.0500	$ 59,089	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Rushville State Bank		X	Line of Credit	Interest Only	12/2014	200,000	108,000	12/19/15	Prime + .5		6
7	JP Morgan Chase		X	Vehicle	$623.40	12/20/12	33,878	21,143	2/3/18	0.0390	1,170	7
8												8
9	TOTAL Facility Related				$8,872.85		$ 1,483,878	$ 1,299,483			$ 60,259	9
	B. Non-Facility Related*											
10												10
11								Offset Interest Income			(1,484)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,484)	14
15	TOTALS (line 9+line14)						$ 1,483,878	$ 1,299,483			$ 58,775	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ None** **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 Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 41,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013	$ 41,043	2
3. Under or (over) accrual (line 2 minus line 1).		$ 43	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 42,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 42,043	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	40,046	8
	2010	39,380	9
	2011	38,825	10
	2012	39,034	11
	2013	41,043	12

Accrual based on prior year tax bill.

Note: Prior year accrual was adjusted as a prior period adjustment for $11,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyders Vaughn Haven COUNTY Schuyler

FACILITY IDPH LICENSE NUMBER 0005363

CONTACT PERSON REGARDING THIS REPORT Vaughn Snyder

TELEPHONE (217) 322-3201 FAX #: (217) 322-6537

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-30-451-008 & 08-30-379-004	Nursing Home	$ 378.64	$ 378.64
2.	08-30-451-006 & 08-30-377-011	Nursing Home	$ 530.12	$ 530.12
3.	08-30-379-003 & 08-30-378-016	Nursing Home	$ 602.62	$ 602.62
4.	08-30-451-007	Nursing Home	$ 1,653.34	$ 1,653.34
5.	08-30-379-001	Nursing Home	$ 180.54	$ 180.54
6.	08-30-379-002	Nursing Home	$ 220.74	$ 220.74
7.	08-30-376-044	Nursing Home	$ 253.70	$ 253.70
8.	08-30-377-012	Nursing Home	$ 406.60	$ 406.60
9.	08-30-377-009	Nursing Home	$ 36,518.16	$ 36,518.16
10.	08-30-377-010	Nursing Home	$ 298.36	$ 298.36
		TOTALS	$ 41,042.82	$ 41,042.82

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,354 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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. [X] (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).

None

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	215,000	1992	$ 41,500	1
2	Resident Care		1997	31,500	2
3	TOTALS	215,000		$ 73,000	3

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	99		1992	1966	$ 1,276,487	$	40	$ 31,912	$ 31,912	$ 706,215	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Years				173,475		Various			173,475	9
10	Drop Ceiling			1993	1,046		15			1,046	10
11	Alarm System			1996	9,173		10			9,173	11
12	Boiler			1996	2,242		10			2,242	12
13	Landscaping			1997	3,684		10			3,684	13
14	Roof			1997	3,427		10			3,427	14
15	Carpet			1997	3,080		10			3,080	15
16	Door			1997	4,494		10			4,494	16
17	Boiler			1997	503		10			503	17
18	A/C - Compressor			1997	839		10			839	18
19	Boiler			1999	2,840		10			2,840	19
20	Air Conditioner			1999	3,500		10			3,500	20
21	Fire Alarm System			1999	55,739		10			55,739	21
22	Parking Lot			1999	55,214		10			55,214	22
23	Landscaping			2000	23,959		10			23,959	23
24	Fire Alarm System			2000	7,032		10			7,032	24
25	Concrete Sidewalks and Drive			2000	3,379		10			3,379	25
26	Landscaping			2000	1,079		10			1,079	26
27	Concrete Sidewalks and Drive			2000	535		10			535	27
28	Plumbing Improvements			2000	2,257		10			2,257	28
29	Wall Coverings			2000	2,870		10			2,870	29
30	Electrical Improvements			2000	1,243		10			1,243	30
31	Door Frame			2000	791		10			791	31
32	Water Softner			2001	6,543		10			6,543	32
33	Landscaping			2001	1,804		10			1,804	33
34	Roofing			2001	2,934		10			2,934	34
35	Door Locks			2002	2,783		10			2,783	35
36											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 Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	Storage	2003	$ 7,281	$	10	$	$	$ 7,281	37
38	Air Conditioners	2004	6,477		10	321	321	6,477	38
39	Air Conditioners	2004	16,031		10	793	793	16,031	39
40	Air Conditioner	2005	4,700		10	470	470	4,465	40
41	Fire Alarm System	2005	3,379		10	338	338	3,211	41
42	Boiler	2005	2,728		10	272	272	2,584	42
43	Sidewalks	2005	4,286		10	428	428	4,066	43
44	Gutters	2005	1,326		10	132	132	1,254	44
45	Landscaping	2005	2,003		10	200	200	1,900	45
46	Sidewalks	2005	4,497		10	450	450	4,275	46
47	Air Conditioners	2005	14,630		10	1,463	1,463	13,899	47
48	Gazebo	2005	12,974		10	1,298	1,298	12,331	48
49	Boiler	2006	2,703		10	270	270	2,295	49
50									50
51	Purchase & Installation of new hydraulic cylinder	2008	33,887		10	3,389	3,389	22,028	51
52									52
53									53
54	Replacement Doors	2009	6,526		10	653	653	3,591	54
55									55
56	Heating Boiler	2010	4,429		10	443	443	1,993	56
57	Hot Water Heater	2010	3,693		10	369	369	1,661	57
58	A/C Units	2010	10,930		10	1,093	1,093	4,919	58
59	Removal of old house	2010	4,000		10	400	400	1,800	59
60	Boiler	2011	11,227		10	1,123	1,123	3,743	60
61	Concrete Driveway and Sidewalk	2012	8,534		15	569	569	1,422	61
62	Boiler	2012	7,153		15	476	476	1,190	62
63	Boiler	2013	5,489		15	366	366	549	63
64	Install Sprinkler System and Backflow Preventer	2013	99,199		15	7,160	7,160	10,740	64
65	Install Sprinkler System	2014	8,869		15	296	296	296	65
66	Water Heater	2014	4,511		15	150	150	150	66
67									67
68	Depreciation Expense per Books			13,200			(13,200)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,944,414	$ 13,200		$ 54,834	$ 41,634	$ 1,216,831	70

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

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 801,193	$	$ 6,835	$ 6,835	Various	$ 795,821	71
72	Current Year Purchases	4,943		247	247	Various	247	72
73	Fully Depreciated Assets					Various		73
74								74
75	TOTALS	$ 806,136	$	$ 7,082	$ 7,082		$ 796,068	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	04 Ford Bus	2005	$ 42,109	$	$	$	5	$ 42,109	76
77	Administrative	2005 Chrysler Town & Country	2012	12,830		2,566	2,566	5	6,415	77
78	Maintenance	2013 Dodge Truck Ram 1500	2012	33,878		6,776	6,776	5	16,940	78
79										79
80	TOTALS			$ 88,817	$	$ 9,342	$ 9,342		$ 65,464	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)	$ 2,912,367	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,200	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 71,258	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 58,058	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,078,363	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 9,203 Description: Copier $3,436, Medical Equipment $5,767
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

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 Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	75,155	$ 147,223	$	75,155	$ 147,223	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,625	8,723		5,625	8,723	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		75,620	144,685	46	75,620	144,731	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				71,995		71,995	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	156,400	$ 300,631	$ 72,041	156,400	$ 372,672	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 Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 313,206	$ 313,206	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,646,468	1,646,468	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,435	99,435	6
7	Other Prepaid Expenses	22,791	22,791	7
8	Accounts Receivable (owners or related parties)	46,311	46,311	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,128,211	$ 2,128,211	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		73,000	13
14	Buildings, at Historical Cost		1,276,487	14
15	Leasehold Improvements, at Historical Cost	366,439	667,927	15
16	Equipment, at Historical Cost	272,472	894,953	16
17	Accumulated Depreciation (book methods)	(348,469)	(2,078,363)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 290,442	$ 834,004	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,418,653	$ 2,962,215	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 388,598	$ 388,598	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	108,000	108,000	29
30	Accrued Salaries Payable	172,828	172,828	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000	42,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Liabilities	81,257	81,257	36
37	See Schedule 17A	269,888	269,888	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,062,571	$ 1,062,571	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,143	21,143	39
40	Mortgage Payable		1,170,340	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)**	$ 21,143	$ 1,191,483	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,083,714	$ 2,254,054	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,334,939	$ 708,161	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,418,653	$ 2,962,215	48

***(See instructions.)**

Snyders Vaughn Haven
Provider # 005363
1/01/14 to 12/31/14

Schedule 17A

XV: Special Services	**Operating**	**After Consolidation**
Line 37- Other Current Liabilities		
V.I Snyder Loan	164,907	164,907
J.R. Snyder Loan	99,298	99,298
Due to JRSCC	5,683	5,683
	269,888	269,888

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,738,747	1
2	Restatements (describe):		2
3	**Prior Period Adjustment-R/E Tax Accrual, Ppd Ins**	(17,238)	3
4	**Post Closing Adjustments (depreciation)**	(12,483)	4
5	**Rounding**	17	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,709,043	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(374,104)	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)**	$ (374,104)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,334,939	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,496,334	1
2	Discounts and Allowances for all Levels	(334,930)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,161,404	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,899	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 94,899	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	887	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	598	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,266	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,595	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,346	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,484	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,484	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income (Offset in Col 7, P3)	145	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 145	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,270,278	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	685,957	31
32	Health Care	1,339,487	32
33	General Administration	502,450	33
	B. Capital Expense		
34	Ownership	209,616	34
	C. Ancillary Expense		
35	Special Cost Centers	762,677	35
36	Provider Participation Fee	144,195	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,644,382	40
41	**Income before Income Taxes (line 30 minus line 40)****	(374,104)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (374,104)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,169,953	44
45	Private Pay - Net Inpatient Revenue	1,097,091	45
46	Medicare - Net Inpatient Revenue	894,360	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,161,404	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No-Note A If not, please attach a reconciliation.**

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

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

Note A-This entity is a cash basis tax payer

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	1,200	1,200	$ 29,993	$ 24.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,535	2,582	60,779	23.54	3
4	Licensed Practical Nurses	17,144	17,848	316,355	17.72	4
5	CNAs & Orderlies	46,504	48,645	517,291	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,918	1,946	19,135	9.83	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	38,145	18.34	11
12	Dietician					12
13	Food Service Supervisor	2,099	2,240	25,944	11.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,588	17,256	159,842	9.26	15
16	Dishwashers					16
17	Maintenance Workers	5,883	6,080	62,256	10.24	17
18	Housekeepers	7,488	7,733	71,731	9.28	18
19	Laundry	5,676	6,012	55,157	9.17	19
20	Administrator	3,120	3,120	46,440	14.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,198	5,374	57,780	10.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,433	122,116	$ 1,460,848 *	$ 11.96	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		$		35
36	Medical Director	Monthly	1,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	641	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	990	L11, C3	44
45	Social Service Consultant	Monthly	3,840	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 7,271		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Snyder	Administrator	0	$ 5,400
David Grate	Administrator/Asst Administrator	0	41,040
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 46,440

B. Administrative - Other

Description	Amount
Management Fees-SAK Management	$ 15,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 15,800

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Services	$ 1,709
Elevator Safety Services	Inspect Elevator	170
Gordan & Kramer	Accounting	6,200
Templin Healthcare Accounting	Accounting	9,518
Duane Morris	Legal	68,995
Legat Architects	Architects	370
Ability	Data Processing	2,256
Simple LTC	Data Processing	968
Michigan Peer Review Org.	Peer Review	5,375
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 95,561

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,217
Unemployment Compensation Insurance	9,716
FICA Taxes	110,855
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Relations & Benefits	7,824
TOTAL (agree to Schedule V, line 22, col.8)	$ 178,612

* Attach copy of IMRF notifications

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

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 49)	496
Patient Background Checks	
Illinois Health Care Association	3,187
Miscellaneous Licenses & Fees	1,140
Miscellaneous Dues	787
Less: IHCA Lobbying Dues @ 38.39%	(1,224)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,386

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,724
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,724

**See instructions.

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Snyders Vaughn Haven # 0005363 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. **IHCA - $3,187**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **765** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **144,195**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **598**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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