

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

<p>I. IDPH License ID Number: <u>0033647</u></p> <p>Facility Name: <u>Snyder Village Health Center</u></p> <p>Address: <u>1200 East Partridge</u> <u>Metamora</u> <u>61548</u> Number City Zip Code</p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 367-4300</u> Fax # <u>(309) 367-2235</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/30/88</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u> </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Keith Swartzentruber</u> Telephone Number: <u>(309) 367-4300</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:15%; border: 1px solid black; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____ (Type or Print Name) <u>Keith Swartzentruber</u> (Title) <u>Executive Director</u></td> </tr> <tr> <td style="width:15%; border: 1px solid black; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin</u> <u>Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p style="text-align: right;">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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Keith Swartzentruber</u> (Title) <u>Executive Director</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin</u> <u>Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()
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Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Keith Swartzentruber</u> (Title) <u>Executive Director</u>							
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin</u> <u>Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()							

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village Health Center

0033647 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	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	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,691	23,485	3,935	34,111	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,691	23,485	3,935	34,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.86%

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

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

Out-patient Therapy

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 104 and days of care provided 2,885

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	431,391	16,972	18,053	466,416		466,416	(65,652)	400,764		1
2	Food Purchase		327,281		327,281		327,281	(63,101)	264,180		2
3	Housekeeping	166,224	28,868		195,092		195,092		195,092		3
4	Laundry	89,914	13,534		103,448		103,448		103,448		4
5	Heat and Other Utilities			132,038	132,038		132,038		132,038		5
6	Maintenance	173,879	37,379	34,327	245,585		245,585	(21,799)	223,786		6
7	Other (specify):* Waste Removal			959	959		959		959		7
8	TOTAL General Services	861,408	424,034	185,377	1,470,819		1,470,819	(150,552)	1,320,267		8
	B. Health Care and Programs										
9	Medical Director			3,935	3,935		3,935	(3,935)			9
10	Nursing and Medical Records	2,679,499	153,969	549,572	3,383,040		3,383,040	(23,094)	3,359,946		10
10a	Therapy										10a
11	Activities	237,723	13,083	3,661	254,467		254,467	2,904	257,371		11
12	Social Services	96,061	935	3,945	100,941		100,941		100,941		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,013,283	167,987	561,113	3,742,383		3,742,383	(24,125)	3,718,258		16
	C. General Administration										
17	Administrative	232,833			232,833		232,833	(66,684)	166,149		17
18	Directors Fees										18
19	Professional Services			125,710	125,710		125,710	(28,733)	96,977		19
20	Dues, Fees, Subscriptions & Promotions			40,614	40,614		40,614	(14,564)	26,050		20
21	Clerical & General Office Expenses	424,979	24,687	29,434	479,100		479,100	(124,212)	354,888		21
22	Employee Benefits & Payroll Taxes			998,113	998,113		998,113	(43,249)	954,864		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,051	18,051		18,051	(252)	17,799		24
25	Other Admin. Staff Transportation			4,657	4,657		4,657	(126)	4,531		25
26	Insurance-Prop.Liab.Malpractice			109,284	109,284		109,284		109,284		26
27	Other (specify):*										27
28	TOTAL General Administration	657,812	24,687	1,325,863	2,008,362		2,008,362	(277,820)	1,730,542		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,532,503	616,708	2,072,353	7,221,564		7,221,564	(452,497)	6,769,067		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Snyder Village Health Center

#0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			343,715	343,715		343,715	(5,478)	338,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,014	12,014		12,014	(7,647)	4,367			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,112	1,112		1,112		1,112			35
36	Other (specify):*											36
37	TOTAL Ownership			356,841	356,841		356,841	(13,125)	343,716			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	29,558	173,627	634,294	837,479		837,479	(3,924)	833,555			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,207	245,207		245,207		245,207			42
43	Other (specify):* Disallowed Costs	107,692		140,112	247,804		247,804	(247,804)				43
44	TOTAL Special Cost Centers	137,250	173,627	1,019,613	1,330,490		1,330,490	(251,728)	1,078,762			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,669,753	790,335	3,448,807	8,908,895		8,908,895	(717,350)	8,191,545			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(63,101)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,220)	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	(5,478)	30		9
10	Interest and Other Investment Income	(7,647)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,014)	20		17
18	Fines and Penalties	(16,100)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,058)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,639)	43		24
25	Fund Raising, Advertising and Promotional	(165,006)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(394,087)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (717,350)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (717,350)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village Health Center

ID# 0033647

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Service Fee income - Administrative	\$ (26,674)	17	1
2	Offset Service Fee income - Administrative	(8,343)	19	2
3	Offset Service Fee income - Administrative	(2,150)	20	3
4	Offset Service Fee income - Administrative	(38,017)	21	4
5	Offset Service Fee income - Administrative	(13,848)	22	5
6	Offset Service Fee income - Administrative	55,000	43	6
7	Offset Service Fee income - Marketing/fundraising	(3,156)	43	7
8	Offset Service Fee income/exp - Activities/Trans	2,904	11	8
9	Offset Service Fee income - Dietary	(65,652)	1	9
10	Offset Service Fee income - Maintenance	(24,876)	6	10
11	Offset Service Fee income - Therapy	(3,924)	39	11
12	Offset Service Fee income - Nursing	(23,064)	10	12
13	Offset Service Fee income - Administrative	(33,342)	17	13
14	Offset Service Fee income - Administrative	(12,204)	19	14
15	Offset Service Fee income - Administrative	(6,600)	20	15
16	Offset Service Fee income - Administrative	(74,629)	21	16
17	Offset Service Fee income - Administrative	(25,581)	22	17
18	Offset Service Fee income - Administrative	(26,000)	43	18
19	Offset Service Fee income - Administrative	(6,668)	17	19
20	Offset Service Fee income - Administrative	(5,128)	19	20
21	Offset Service Fee income - Administrative	(1,800)	20	21
22	Offset Service Fee income - Administrative	(11,440)	21	22
23	Offset Service Fee income - Administrative	(3,820)	22	23
24	Offset Service Fee income - Administrative	(13,000)	43	24
25	Offset Misc. Other Revenue	(30)	10	25
26	Disallow Brokerage Fees	(20,683)	43	26
27	Offset Purchase Rebates	(2,018)	6	27
28	Offset Purchase Rebates	(252)	24	28
29	Offset Purchase Rebates	(126)	25	29
30	Offset Purchase Rebates	(126)	21	30
31	Disallow Invoice Entered Two Times	(3,935)	9	31
32	Expense Repairs under \$2,500	5095	6	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	(394,087)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Commerce Bank		X	Building	\$5,270.00	8/1/87	\$ 3,450,000	\$ 47,624	9/1/26	0.0167	\$ 1,509	1						
2	Goodfield State Bank		X	Building	\$1,700.00	12/1/12	300,000	229,340	12/1/27	0.0325	8,234	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Gift Annuity		X	Building	\$510.00	Various	84,000	12,435	Various	Various	2,271	6						
7												7						
8												8						
9	TOTAL Facility Related				\$7,480.00		\$ 3,834,000	\$ 289,399			\$ 12,014	9						
B. Non-Facility Related*																		
10												10						
11									Interest Income offset		(7,647)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (7,647)	14						
15	TOTALS (line 9+line14)						\$ 3,834,000	\$ 289,399			\$ 4,367	15						

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 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 2018 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:	2013	N/A	8
	2014	N/A	9
	2015	N/A	10
	2016	N/A	11
	2017	N/A	12
This facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for the real estate tax is required.			

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 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 2017 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 2017.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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:

1/1/2018

Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,020 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories 1

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 - 170 Cottages @ approximately 318,000 Ft2

Snyder Village Assisted Living - 65 units @ approximately 45,900 Ft2

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for index. Rows include Nursing Home, See Attached Sch 11A, and TOTALS.

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village Health Center

Period Beginning 1/1/2018
 Period End 12/31/2018

Schedule 11A

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	61		1988	1988	\$ 1,929,231	\$ 42,872	45	\$ 42,872	\$	\$ 1,307,594	4
5			1992	1992	127,495	2,833	45	2,833		75,313	5
6			1992	1992	33,830		25			33,830	6
7	18		1994	1994	600,872	13,353	45	13,353		331,597	7
8	26		1994	1994	1,256,597	27,924	45	27,924		672,506	8
	Improvement Type**										
9		Fire Control System		1989	5,152		20			5,152	9
10		Century Tub		1989	7,694		10			7,694	10
11		Asphalt		1990	1,820		20			1,820	11
12		Alzheimer's Courtyard		1990	3,644		10			3,644	12
13		Heat Exchanger		1990	1,650		10			1,650	13
14		Tub		1991	1,465		10			1,465	14
15		Door Locks		1991	1,400		20			1,400	15
16		Door Locks		1992	1,200		20			1,200	16
17		Patio		1992	1,219		10			1,219	17
18		Entrance Light		1993	619		10			619	18
19		Land Improvement		1994	25,546		20			25,546	19
20		Services Windows		1995	198,184	4,481	45	4,404	(77)	102,996	20
21		Landscaping		1994	8,221		20	62	62	8,221	21
22		Canopy		1995	1,102		20			1,102	22
23		Electrical Maintenance		1995	595		15			595	23
24		Door Locks		1995	505		15			505	24
25		Front Canopy		1996	44,780	999	45	995	(4)	21,382	25
26		Tower		1996	7,360		20			7,360	26
27		Door Open		1996	3,344		10			3,344	27
28		Landscaping		1997	1,500		20			1,500	28
29		Front Door Wiring		1997	1,396		20			1,396	29
30		Kelly Glass		1998	3,527		20	6	6	3,527	30
31		MTCO Phone System		1998	10,865	757	25	435	(322)	8,267	31
32		Carpet		1998	15,719		10			15,719	32
33		Heater		1999	1,784		10			1,784	33
34		Security Camera		1999	2,510		15			2,510	34
35		Motion Detector		1999	790		10			790	35
36		Shelving		1999	673		10			673	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic Door Open	2000	\$ 5,449	\$	15	\$	\$	\$ 5,449	37
38	Blacktop	2000	21,736	1,087	20	1,087		19,656	38
39	Sunroom	2000	86,294	1,920	45	1,920		35,517	39
40	Generator	2000	35,213	1,810	20	1,810		33,411	40
41	Time Clock	2000	7,789		5			7,789	41
42	Motion Detector	2000	5,716		10			5,716	42
43	Nursing Office Addition	2001	759,951	16,707	45	16,707		292,463	43
44	Nurse Office Addition	2001	4,943	247	20	247		4,384	44
45	Blacktop	2001		603	20		(603)		45
46	Roof	2002	36,779		15			36,779	46
47	Hall 2 Room Alert	2002	5,015		5			5,015	47
48	Door, Tile, Drapes, Wall	2003	4,557		8			4,557	48
49	Door	2004	1,640		3			1,640	49
50	Roam Alert	2004	4,488		5			4,488	50
51	Carpet Hall 2	2004	856		5			856	51
52	Drapery	2004	2,335		5			2,335	52
53	Heat Pump	2005	1,051		10			1,051	53
54	Water Heater	2005	4,240		10			4,240	54
55	Therapy room door	2005	755		5			755	55
56	Hall 1 Nurses Station	2005	9,010	451	20	451		5,975	56
57	Service Door	2005	950		3			950	57
58	Blacktop Sealcoat	2005	3,373		5			3,373	58
59	Heat pump	2006	4,981		10			4,981	59
60	Heat pump	2006	4,260		10			4,260	60
61	Hall carpeting	2006	21,377		10			21,377	61
62	Concrete Sidewalk	2006		45	20		(45)		62
63	Alarm system	2007	3,304		5			3,304	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,338,351	\$ 116,089		\$ 115,106	\$ (983)	\$ 3,164,241	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,338,351	\$ 116,089		\$ 115,106	\$ (983)	\$ 3,164,241	1
2	Heat pump	2007	9,181		10			9,181	2
3	Hall 2 flooring	2007			10				3
4	Front signage	2008	15,386	1,154	10	1,151	(3)	15,386	4
5	Blacktop	2008	15,488	774	20	774		7,867	5
6	Heat Pump	2008	10,609	530	10	530		10,609	6
7	Rm flooring, wall & window covering, wood work, windows	2009	40,354	2,018	20	2,018		18,665	7
8	Energy management system controls	2009	19,344	1,934	10	1,934		19,335	8
9	Plumbing & sprinkler system	2009	21,157	1,937	10	1,937		20,109	9
10	Thermo systems	2009		181	10		(181)		10
11	Fencing	2009		91	10		(91)		11
12	Courtyard landscaping	2009	2,539	254	10	254		2,349	12
13	Window blinds for dining room	2009			5				13
14	Cable TV wiring	2009	33,168		8			33,168	14
15	Heat Pump	2010	16,061	1,606	10	1,606		13,517	15
16	Motion Detector & Electrical Fixtures	2010	9,081	908	10	908		7,719	16
17	Blacktop	2010	27,905	1,395	20	1,395		11,860	17
18	Schrepfer front door	2010	3,766	377	10	377		3,110	18
19	Fire system	2010			5				19
20	Heat Pump halls 1, 2, 3	2011	10,345	1,035	10	1,035		8,192	20
21	Health Center HallI Room Design/Drawings/Engineering	2011	13,665	1,367	10	1,367		10,819	21
22	Wall mounted shadow box & bulletin board	2011	2,528	253	10	253		2,002	22
23	Light fixtures, switches, outlets, breakers, wiring	2011	36,050	1,442	25	1,442		11,414	23
24	Toilets, sinks, faucets, piping, grab bar, lav top	2011	9,847	393	25	393		3,111	24
25	Corner & medicine cabinet, headboards	2011	9,053	905	10	905		7,163	25
26	Wall studs, wall board, paint, trim & guards	2011	6,120	245	25	245		1,939	26
27	Curtains w/track	2011	3,386	339	10	339		2,683	27
28	Chair rail & oak light boxes	2011	6,234	249	25	249		1,971	28
29	Window blinds & valances	2011	8,247	330	25	330		2,612	29
30	Wall protection 4'x8' sheets for resident rooms	2011	26,660	1,066	25	1,066		8,017	30
31	Health Center HallI Dining Rm Design/Drawings/Engineering	2011	124,070	2,757	45	2,757		20,734	31
32	Dining room flooring	2011	20,000	800	25	800		6,016	32
33	Hall I & 13 resident room flooring	2011	22,900	916	25	916		6,889	33
34	TOTAL (lines 1 thru 33)		\$ 5,861,495	\$ 141,345		\$ 140,087	\$ (1,258)	\$ 3,430,678	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,861,495	\$ 141,345		\$ 140,087	\$ (1,258)	\$ 3,430,678	1
2	Dining rm exhaust hood & fan	2011	5,408	216	25	216		1,625	2
3	Dining rm cabinetry & counter top	2011	4,700	470	10	470		3,352	3
4	Dining rm constr:walls-windows-doors,heat-a/c,plumbing,electrica	2011	480,326	8,567	45	10,674	2,107	81,229	4
5	Hall 2 fencing	2011		300	10		(300)		5
6	Sprinkler system improvements	2011	27,961	3,062	10	2,796	(266)	19,914	6
7	Two heat pumps	2011	4,991	499	10	499		3,753	7
8	Garbage Disposal	2011			5				8
9	Kitchen heat pump	2011	5,140	514	10	514		3,768	9
10	WI FI	2012	12,791	1,599	8	1,599		11,193	10
11	Sprinkler Heads	2012	12,531	1,253	10	1,253		8,771	11
12	Fire Supression Hall 1 & 2	2012	6,582	658	10	658		4,496	12
13	Hall 3 Remodeling - flooring, fixtures, electrical, wallpaper, painti	2012	132,957	7,201	25	5,318	(1,883)	36,342	13
14	Sprinkler system repair	2012	2,913		5			2,913	14
15	Heat Pumps	2012	4,655	466	10	466		2,936	15
16	Landscaping / Drainage work	2012	1,606	80	20	80		493	16
17	Front Entry Way redesign, Energy Efficient Double Door Entry, F	2013	37,567	1,779	25	1,503	(276)	8,640	17
18	Hall 4 Renovation- New flooring, rewiring, Heat Pumps, Lighting,	2013	100,470	5,470	25	4,019	(1,451)	22,103	18
19	Front Entry Way - Lobby flooring and molding	2013		77	25		(77)		19
20	Hall 4 Flooring	2013	11,545	1,155	10	1,155		6,352	20
21	Roof Replacement	2013	4,150	588	20	208	(380)	1,107	21
22	Nurses Station Flooring	2013	12,699	1,270	10	1,270		6,456	22
23	4 new Heat Pumps	2013	9,026	903	10	903		5,099	23
24	Blacktop Parking lot	2013	32,917	1,646	20	1,646		8,504	24
25	Roof Replacement -office, entrance, dining, laundry & maint room	2014	21,305	1,065	20	1,065		4,615	25
26	Hall 2 Renovations - Wall boards, painting and fixtures	2014	11,215	1,121	10	1,121		5,046	26
27	Hall 2 Renovations - electrical, walls and wall protections	2014	66,001	2,640	25	2,640		11,880	27
28	Install New Fire Alarm System	2015	126,696	5,075	25	5,068	(7)	22,506	28
29	Build New Entryway for Kitchen	2014	3,161	316	10	316		1,422	29
30	Dining Room Remodel- Flooring, Cabinets & Countertops	2014	4,265	1,254	10	427	(827)	1,920	30
31	Replace 2 heat pumps	2014	2,977	298	10	298		1,489	31
32	New Heat Pump/ A/C installed in ceiling	2014	3,849	770	5	770		3,337	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,011,899	\$ 191,657		\$ 187,039	\$ (4,618)	\$ 3,721,939	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,011,899	\$ 191,657		\$ 187,039	\$ (4,618)	\$ 3,721,939	1
2	New Carpeting - Hall 2	2015	27,962	2,796	10	2,796		11,184	2
3	Complete Fire Alarm System	2015	9,118	986	15	608	(378)	2,431	3
4	Electrical Wiring - 3 Rooms in Hall 2	2015		37	25		(37)		4
5	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	61,421	3,071	20	3,071		9,981	5
6	Roof Replacement-Halls 2, 3, 4, Office and Entry	2015	9,766	488	20	488		1,545	6
7	New Flooring - Dining Room	2015	3,362	336	10	336		1,008	7
8	Electrical Wiring - 3 Rooms in Hall 2	2015	2,807	281	10	281		1,100	8
9	Replace Heat Pumps	2015	3,696	370	10	370		1,480	9
10	Install New Elevator Pit	2015	4,180	418	10	418		1,428	10
11	Nurse Call System	2015	74,784	8,678	10	7,478	(1,200)	24,927	11
12	Walk In Cooler	2015	10,538	1,054	10	1,054		4,128	12
13	Wanderguard System	2015	20,800	880	10	2,080	1,200	8,147	13
14	Replace Heat Pumps	2015	7,413	741	10	741		2,408	14
15	New Cabinets and Countertops - Dining Room	2015	4,282	428	10	428		1,284	15
16	New Flooring - Assisted Dining Room	2016	5,637	564	10	564		1,623	16
17	Replace Bistro Door	2016		181	10		(181)		17
18	Replace Heat Pumps	2016	6,401	640	10	640		1,867	18
19	Patio - Maintenance Building	2016	8,000	400	20	400		967	19
20	Door Alarms	2016	4,959	496	10	496		1,364	20
21	Built-In Whirlpool Tub	2016	15,954	1,595	10	1,595		4,121	21
22	Roofing-Therapy Area	2016	11,739	587	20	587		1,419	22
23	Roofing - Hall 2	2016	11,127	556	20	556		1,158	23
24	Sump Pump in Basement	2016	2,884	288	10	288		648	24
25	Cabling for Network System	2016	16,000	1,600	10	1,600		3,467	25
26	Replace Bistro Door to Comply with Life Safety	2017	5,514	551	10	551		1,056	26
27	Piping & Plumbing Work to Bring to Code	2017	11,777	744	20	589	(155)	723	27
28	Replace Flooring in Therapy Entrance	2017	6,769	677	10	677		677	28
29	Replace Doors in Kitchen, Storage & Breakroom	2017	4,267	427	10	427		783	29
30	Install Emergency Power Breakers	2017	4,064	406	10	406		609	30
31	Walk-In Freezer	2017	8,970	897	10	897		1,121	31
32	300 Hospital Grade Recepticals,Outlets 20 amp	2018	3,618	271	10	271		271	32
33	Replace Kichen Hoods & Exhaust Fans	2018	7,493	500	10	500		500	33
34	TOTAL (lines 1 thru 33)		\$ 7,387,201	\$ 223,601		\$ 218,232	\$ (5,369)	\$ 3,815,364	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,387,201	\$ 223,601		\$ 218,232	\$ (5,369)	\$ 3,815,364	1
2	Replace Flooring/Electrical Wiring/Walls - Dietary Office	2018	2,613	87	20	87		87	2
3	Fire System Piping	2018		48			(48)		3
4	Fire Suppression Piping - Repair Leak	2018	2,922	24	10	24		24	4
5	Install New Camera System Throughout Facility	2018	12,601		10				5
6	Replace Ceiling Tiles Throughout Facility	2018	2,646	22	10	22		22	6
7	Cat 6 Wiring for TV's	2018		18			(18)		7
8	Replace Kitchen Hood	2018	2,506	167	10	167		167	8
9	New Heat Pump	2018	6,140	154	10	154		154	9
10	Sprinkler Replacement	2018		43			(43)		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)		\$ 7,416,629	\$ 224,164		\$ 218,686	\$ (5,478)	\$ 3,815,818	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	\$ 988,194	\$ 104,666	\$ 104,667	\$ 1	Various	\$ 704,794	71
72	Current Year Purchases	128,831	7,919	7,919		3-10 Yrs	7,919	72
73	Fully Depreciated Assets	1,082,080	3,241	3,241		Various	1,082,080	73
74								74
75	TOTALS	\$ 2,199,105	\$ 115,826	\$ 115,827	\$ 1		\$ 1,794,793	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nurse on Call	2002 Chevy Cavaliar	2010	4,548	\$	\$		4	\$ 4,548	76
77	Patient Transport	2010 Transit Connect XLT	2015	18,623	3,725	3,724	(1)	5	12,726	77
78										78
79										79
80	TOTALS			\$ 23,171	\$ 3,725	\$ 3,724	\$ (1)		\$ 17,274	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)	\$ 9,726,955	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 343,715	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 338,237	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,478)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,627,885	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 1,714,904	92
93	Bistros for Hall, II, III & I		93
94	Hall 2 Pavilions and Expansion		94
95		\$ 1,714,904	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 1,112 Description: Copier YES NO

(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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	9,009	\$ 157,361	\$	9,009	\$ 157,361	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,206	79,339		2,206	79,339	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		15,494	363,962	3,564	15,494	367,526	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 prescripts				170,063		170,063	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Massage Therapist</u>	39(1)	264		6,592			264	6,592	12
13	Other (specify):									13
14	TOTAL			\$ 6,592	26,709	\$ 600,662	\$ 173,627	26,973	\$ 780,881	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 325,956	\$ 325,956	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>199,000</u>)	554,282	554,282	3
4	Supply Inventory (priced at <u>FIFO</u>)	44,134	44,134	4
5	Short-Term Investments			5
6	Prepaid Insurance	113,467	113,467	6
7	Other Prepaid Expenses	8,858	8,858	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany Receivable</u>	1,129,903	1,129,903	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,176,600	\$ 2,176,600	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,303,087	3,303,087	12
13	Land	88,050	88,050	13
14	Buildings, at Historical Cost	8,031,030	7,416,629	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,574,159	2,222,276	16
17	Accumulated Depreciation (book methods)	(5,432,629)	(5,627,885)	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): <u>Construction in Progress</u>	1,714,904	1,714,904	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,278,601	\$ 9,117,061	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,455,201	\$ 11,293,661	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 246,962	\$ 246,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,444	215,444	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,182	22,182	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	<u>Other Accrued Liabilities</u>	4,203	4,203	36
37	<u>Accrued 401K Plan</u>	86,000	86,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 574,791	\$ 574,791	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	289,399	289,399	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)	\$ 289,399	\$ 289,399	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 864,190	\$ 864,190	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,591,011	\$ 10,429,471	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,455,201	\$ 11,293,661	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,278,511	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,278,511	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,312,500	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)	\$ 1,312,500	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)	\$ 10,591,011	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,995,323	1
2	Discounts and Allowances for all Levels	(1,878,844)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,116,479	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,467	6
7	Oxygen	28,160	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 307,627	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		12
13	Barber and Beauty Care	3,772	13
14	Non-Patient Meals	63,101	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	32,287	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	132,801	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 231,961	23
D. Non-Operating Revenue			
24	Contributions	1,343,501	24
25	Interest and Other Investment Income***	(208,345)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,135,156	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Service Fee Income</u>	372,012	28
28a	<u>See Pg 19A</u>	58,160	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 430,172	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,221,395	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,470,819	31
32	Health Care	3,742,383	32
33	General Administration	2,008,362	33
B. Capital Expense			
34	Ownership	356,841	34
C. Ancillary Expense			
35	Special Cost Centers	1,085,283	35
36	Provider Participation Fee	245,207	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,908,895	40
41	Income before Income Taxes (line 30 minus line 40)**	1,312,500	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,312,500	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 905,084	44
45	Private Pay - Net Inpatient Revenue	5,531,760	45
46	Medicare - Net Inpatient Revenue	1,264,760	46
47	Other-(specify) <u>Insurance</u>	414,875	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,116,479	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village Health Center

Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 19A

Amount

XVII. INCOME STATEMENT

Line 28a- Other Income

Van Income	6,693
Miscellaneous Income	2,070
Purchase Rebates	2,522
Realized Gain on Securities	46,875

Total	<u><u>58,160</u></u>
--------------	-----------------------------

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,899	2,120	\$ 88,461	\$ 41.73	1
2	Assistant Director of Nursing	1,755	1,993	66,578	33.41	2
3	Registered Nurses	9,132	10,162	315,461	31.04	3
4	Licensed Practical Nurses	18,227	19,759	525,017	26.57	4
5	CNAs & Orderlies	74,499	80,319	1,276,930	15.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,885	1,981	29,558	14.92	8
9	Activity Director	1,939	2,146	45,425	21.17	9
10	Activity Assistants	15,223	16,065	184,206	11.47	10
11	Social Service Workers	4,756	5,333	96,061	18.01	11
12	Dietician	1,784	2,080	54,886	26.39	12
13	Food Service Supervisor	1,037	1,260	22,872	18.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,826	28,909	353,633	12.23	15
16	Dishwashers					16
17	Maintenance Workers	7,638	8,622	173,879	20.17	17
18	Housekeepers	12,598	13,874	166,224	11.98	18
19	Laundry	6,518	7,282	89,914	12.35	19
20	Administrator	1,922	2,080	92,945	44.69	20
21	Assistant Administrator					21
22	Other Administrative	1,728	2,080	139,888	67.25	22
23	Office Manager	2,469	2,718	77,184	28.40	23
24	Clerical	14,351	15,622	347,795	22.26	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) See Sch 20A	19,865	21,674	522,836	24.12	33
34	TOTAL (lines 1 - 33)	226,051	246,079	\$ 4,669,753 *	\$ 18.98	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	380	\$ 18,053	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	36	2,447	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,907	L10, C3	39
40	Physical Therapy Consultant	Monthly	13,218	L39, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	3,661	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) MDS Consultant	172	12,932	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	642	\$ 56,218		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,274	\$ 106,742	L10, C3	50
51	Licensed Practical Nurses	4,336	188,868	L10, C3	51
52	Certified Nurse Assistants/Aides	10,883	232,676	L10, C3	52
53	TOTAL (lines 50 - 52)	17,493	\$ 528,286		53

SEE ACCOUNTANTS' PREPARATION REPORT

Snyder Village Health Center

Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nursing Support	9,807	10,800	296,122	27.42
Ward Clerk	3,586	4,059	66,085	16.28
CNA Coordinator	2,120	2,120	44,845	21.15
Transportation	592	595	8,092	13.60
Development	3,760	4,100	107,692	26.27
TOTAL	<u>19,865</u>	<u>21,674</u>	<u>522,836</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Keith Swartzentruber	Exec Director	0	\$ 139,888	Workers' Compensation Insurance	\$ 140,071	IDPH License Fee	\$ 1,990	
Heather O'Brien	Administrator	0	92,945	Unemployment Compensation Insurance	12,000	Advertising: Employee Recruitment	2,032	
				FICA Taxes	292,855	Health Care Worker Background Check (Indicate # of checks performed 74)	2,146	
				Employee Health Insurance	345,716	Patient Background Checks 69	2,000	
				Employee Meals		Illinois Aging Services	8,147	
				Illinois Municipal Retirement Fund (IMRF)*		Misc Dues & Licenses	455	
				Employee Pension Plan	82,807	LeadingAge Illinois	8,028	
				Employee Life/Disability	1,954	Relias Learning	2,211	
				Employee Flex Time	28,527	Symbria	3,055	
				Hep B & Employee Physicals	3,765	Less: Public Relations Expense	(4,014)	
				Employee Appreciation	43,994	Non-allowable advertising ()		
				Employee Wellness	3,175	Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 232,833	TOTAL (agree to Schedule V, line 22, col.8)		\$ 26,050		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
N/A			\$	N/A		\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				In-State Travel	
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type		Amount	\$			See Attached Schedule	17,799
Matrixcare	Computer Software		\$ 42,172					
CDS Office Technologies	Computer Service		18,297					
Casamba	Computer Service		4,900					
Kronos	Computer Service		4,921					
Ability Network	Medicare Electronic Filing		4,019					
Sage Software, Inc	Payroll Software		7,256					
E-Solutions	Computer Service		5,640					
Miscellaneous Vendors	Misc. Computer Software		108					
Pentegra	401k Administration		5,779					
Heinold - Banwart	Accounting		13,862					
Templin Healthcare Accounting	Cost Report Preparation		4,646					
See Pg 21A			14,110					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 125,710	\$			Entertainment Expense ()	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Snyder Village Health Center

Period Beginning

1/1/2018

Period End

12/31/2018

Schedule XIX C. Professional Fees

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Provider Trust, Inc.	Healthcare Compliance	1,238
Management Performance Associates, Inc.	Healthcare Compliance	4,404
Seagrove Consulting Group, LLC	Healthcare Compliance	1,203
Michigan Peer Review	Peer Review	3,935
Davis & Campbell L.L.C.	Legal	5,116
Kopon Airdo, LLC	Legal	2,500
Johnson, Bunce & Noble, PC	Legal	3,214
Prior Year Legal Accrual Reversal	Legal	(7,500)
	Total	14,110

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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. 8,028 LeadingAge Illinois
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,572 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 245,207
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 63,101
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold-Banwart, Ltd.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT