



Facility Name & ID Number Snow Valley Nursing & Rehab Center

# 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	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	51	Skilled (SNF)	51	18,615	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	51	TOTALS	51	18,615	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	11,030	4,313	
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,030	4,313	1,429	16,772	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.10%

D. How many bed-hold days during this year were paid by the Department? 0 (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

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 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/2003 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 51 and days of care provided 1,192

Medicare Intermediary AdminaStar Federal Springfield

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Snow Valley Nursing &amp; Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	112,687	8,117	6,073	126,877		126,877	3,078	129,955		1
2	Food Purchase		88,701		88,701		88,701	284	88,985		2
3	Housekeeping	38,973	8,733	5,872	53,578		53,578	(698)	52,880		3
4	Laundry	30,005	10,047		40,052		40,052	(583)	39,469		4
5	Heat and Other Utilities			38,114	38,114		38,114	663	38,777		5
6	Maintenance	47,962		26,872	74,834		74,834	3,044	77,878		6
7	Other (specify):*			8	8		8	612	620		7
8	<b>TOTAL General Services</b>	229,627	115,598	76,939	422,164		422,164	6,400	428,564		8
<b>B. Health Care and Programs</b>											
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	989,643	41,621	13,300	1,044,564		1,044,564	(3,391)	1,041,173		10
10a	Therapy		109	76,200	76,309		76,309	157	76,466		10a
11	Activities	31,925	3,000	784	35,709		35,709		35,709		11
12	Social Services	1,820			1,820		1,820		1,820		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*			1,221	1,221		1,221	(369)	852		15
16	<b>TOTAL Health Care and Programs</b>	1,023,388	44,730	99,905	1,168,023		1,168,023	(3,603)	1,164,420		16
<b>C. General Administration</b>											
17	Administrative	89,417		107,124	196,541		196,541	(38,246)	158,295		17
18	Directors Fees										18
19	Professional Services			41,523	41,523		41,523	(327)	41,196		19
20	Dues, Fees, Subscriptions & Promotions			22,806	22,806		22,806	1,626	24,432		20
21	Clerical & General Office Expenses	77,995	12,482	22,162	112,639		112,639	53,748	166,387		21
22	Employee Benefits & Payroll Taxes			215,073	215,073		215,073	(6)	215,067		22
23	Inservice Training & Education			699	699		699		699		23
24	Travel and Seminar			2,312	2,312		2,312	1,468	3,780		24
25	Other Admin. Staff Transportation			2,649	2,649		2,649		2,649		25
26	Insurance-Prop.Liab.Malpractice			48,181	48,181		48,181	569	48,750		26
27	Other (specify):*							8,140	8,140		27
28	<b>TOTAL General Administration</b>	167,412	12,482	462,529	642,423		642,423	26,972	669,395		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,420,427	172,810	639,373	2,232,610		2,232,610	29,769	2,262,379		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 &amp; ID Number

Snow Valley Nursing &amp; Rehab Center

#0046185

Report Period Beginning:

01/01/05

Ending:

12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			6,466	6,466		6,466	52,877	59,343			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,284	4,284		4,284	47,606	51,890			32
33	Real Estate Taxes			17,259	17,259		17,259	545	17,804			33
34	Rent-Facility & Grounds			152,333	152,333		152,333	(149,751)	2,582			34
35	Rent-Equipment & Vehicles			3,353	3,353		3,353	(247)	3,106			35
36	Other (specify):*							4,570	4,570			36
37	<b>TOTAL Ownership</b>			183,695	183,695		183,695	(44,400)	139,295			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,885		74,885		74,885	(2,627)	72,258			39
40	Barber and Beauty Shops			4,493	4,493		4,493		4,493			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,923	27,923		27,923		27,923			42
43	Other (specify):* <b>Nonallowable Costs</b>			13,062	13,062		13,062	(13,062)				43
44	<b>TOTAL Special Cost Centers</b>		74,885	45,478	120,363		120,363	(15,689)	104,674			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,420,427	247,695	868,546	2,536,668		2,536,668	(30,320)	2,506,348			45

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

\*\*See Schedule of adjustments attached at end of cost 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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(614)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	264	30		9
10	Interest and Other Investment Income	(64)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(790)	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	(344)	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	(3,283)	43		24
25	Fund Raising, Advertising and Promotional	(4,970)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(392)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(16,816)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (27,009)		\$	30

OHF 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	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)	(3,311)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (3,311)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (30,320)		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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**Snow Valley Nursing & Rehab Center**

**Provider #: 0046185**

**01/01/05 to 12/31/05**

**Schedule 5A**

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Offset Vending Income	(476)	2
Offset Other Income	(2)	21
To disallow Theft Loss	(536)	43
To disallow Collection Fees	(8)	43
To disallow Laboratory	(774)	43
To disallow Radiology	(2,357)	43
To disallow Legal Fees	(7,500)	19
To disallow Goodwill	(5,163)	31
	(16,816)	

Snow Valley Nursing & Rehab Center

ID# 0046185

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Misc. - Part A	\$	1
2	Labs - Part A		2
3	X-Rays - Part A		3
4	Vending Machine Expense		4
5	Disallowed Non-Care Related Real Estate Tax		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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Snow Valley Nursing &amp; Rehab Center

# 0046185 Report Period Beginning:

01/01/05

Ending: 12/31/05

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	1,307	0	0	1,822	0	0	(51)	0	0	3,078	1
2	Food Purchase	(614)	0	0	0	0	1,379	0	0	(5)	0	0	760	2
3	Housekeeping	0	0	0	0	0	0	0	0	(698)	0	0	(698)	3
4	Laundry	0	0	0	0	0	0	0	0	(583)	0	0	(583)	4
5	Heat and Other Utilities	0	0	663	0	0	0	0	0	0	0	0	663	5
6	Maintenance	0	0	3,082	0	0	14	0	0	(52)	0	0	3,044	6
7	Other (specify):*	0	0	383	0	10	219	0	0	0	0	0	612	7
8	<b>TOTAL General Services</b>	(614)	0	5,435	0	10	3,434	0	0	(1,389)	0	0	6,876	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	(3,391)	0	0	(3,391)	10
10a	Therapy	0	0	158	0	0	0	0	0	(1)	0	0	157	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	22	0	(391)	0	0	0	0	0	0	(369)	15
16	<b>TOTAL Health Care and Programs</b>	0	0	180	0	(391)	0	0	0	(3,392)	0	0	(3,603)	16
	<b>C. General Administration</b>													
17	Administrative	0	0	(37,265)	0	0	106	0	0	0	0	0	(37,159)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,084	0	0	2	0	0	0	0	0	6,086	19
20	Fees, Subscriptions & Promotions	0	250	1,425	0	0	3	0	0	(52)	0	0	1,626	20
21	Clerical & General Office Expenses	0	247	53,260	0	0	243	0	0	0	0	0	53,750	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	(6)	0	0	(6)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,384	0	0	84	0	0	0	0	0	1,468	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	494	0	0	75	0	0	0	0	0	569	26
27	Other (specify):*	0	0	8,140	0	0	0	0	0	0	0	0	8,140	27
28	<b>TOTAL General Administration</b>	0	497	33,522	0	0	513	0	0	(58)	0	0	34,474	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(614)	497	39,137	0	(381)	3,947	0	0	(4,839)	0	0	37,747	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	264	45,401	6,907	0	0	40	0	265	0	0	0	52,877 30
31	Amortization of Pre-Op. & Org.	0	9,733	0	0	0	0	0	0	0	0	0	9,733 31
32	Interest	(64)	46,288	0	1,153	0	135	0	94	0	0	0	47,606 32
33	Real Estate Taxes	0	0	0	545	0	0	0	0	0	0	0	545 33
34	Rent-Facility & Grounds	0	(152,333)	0	2,582	0	0	0	0	0	0	0	(149,751) 34
35	Rent-Equipment & Vehicles	0	0	0	465	0	8	0	(720)	0	0	0	(247) 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>200</b>	<b>(50,911)</b>	<b>6,907</b>	<b>4,745</b>	<b>0</b>	<b>183</b>	<b>0</b>	<b>(361)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(39,237) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	(1,272)	0	0	(1,355)	0	0	(2,627) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(9,779)	392	0	0	0	0	0	0	0	0	0	(9,387) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(9,779)</b>	<b>392</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,272)</b>	<b>0</b>	<b>0</b>	<b>(1,355)</b>	<b>0</b>	<b>0</b>	<b>(12,014) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(10,193)</b>	<b>(50,022)</b>	<b>46,044</b>	<b>4,745</b>	<b>(381)</b>	<b>2,858</b>	<b>0</b>	<b>(361)</b>	<b>(6,194)</b>	<b>0</b>	<b>0</b>	<b>(13,504) 45</b>

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Gale Rothner	51%					
Aaron Shpayer	49%	See Attached List		See Attached List		
		Pavilion of Waukegan	Waukegan			
				Snow Valley Property, LLC	Evanston, IL	Bldg Company

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	20 License and Fees	\$	Snow Valley Property LLC	100.00%	\$ 250	\$ 250	1
2	V	21 Office Expense		Snow Valley Property LLC	100.00%	26	26	2
3	V	21 Bank Charges		Snow Valley Property LLC	100.00%	221	221	3
4	V	30 Depreciation		Snow Valley Property LLC	100.00%	45,401	45,401	4
5	V	31 Amortization - Loan Cost		Snow Valley Property LLC	100.00%	4,570	4,570	5
6	V	31 Amortization - Goodwill		Snow Valley Property LLC	100.00%	5,163	5,163	6
7	V	32 Interest		Snow Valley Property LLC	100.00%	46,288	46,288	7
8	V	33 Real Estate Tax	17,259	Snow Valley Property LLC	100.00%	17,259		8
9	V	34 Rent	152,333	Snow Valley Property LLC	100.00%		(152,333)	9
10	V	43 Replace Tax		Snow Valley Property LLC	100.00%	392	392	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 169,592			\$ 119,570	\$ * (50,022)	14

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center# 0046185Report Period Beginning: 01/01/05Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary - Salary	\$	Care Centers, Inc.	100.00%	\$ 1,202	\$ 1,202
16	V	01 Dietary - Other		Care Centers, Inc.	100.00%	105	105
17	V	05 Utilities		Care Centers, Inc.	100.00%	663	663
18	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	1,462	1,462
19	V	06 Maintenance - Other		Care Centers, Inc.	100.00%	1,620	1,620
20	V	07 Employee Benefits - General Serv.		Care Centers, Inc.	100.00%	383	383
21	V	10 Nursing - Salary		Care Centers, Inc.	100.00%		
22	V	10 Nursing - Other		Care Centers, Inc.	100.00%		
23	V	10a Therapy - Salary		Care Centers, Inc.	100.00%	158	158
24	V	10a Therapy Other		Care Centers, Inc.	100.00%		
25	V	15 Employee Benefits - Healthcare		Care Centers, Inc.	100.00%	22	22
26	V	17 Administrative - Salary		Care Centers, Inc.	100.00%	8,772	8,772
27	V	17 Administrative - Other	47,124	Care Centers, Inc.	100.00%	1,087	(46,037)
28	V	19 Professional Fees		Care Centers, Inc.	100.00%	6,084	6,084
29	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	1,425	1,425
30	V	21 Office & Clerical - Salary		Care Centers, Inc.	100.00%	47,963	47,963
31	V	21 Office & Clerical - Other		Care Centers, Inc.	100.00%	5,297	5,297
32	V	22 Employee Benefits		Care Centers, Inc.	100.00%		
33	V	23 Inservice & Education		Care Centers, Inc.	100.00%		
34	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	1,384	1,384
35	V	25 Other Admin. Staff Transportation		Care Centers, Inc.	100.00%		
36	V	26 Insurance		Care Centers, Inc.	100.00%	494	494
37	V	27 Employee Benefits - Admin Serv.		Care Centers, Inc.	100.00%	8,140	8,140
38	V	30 Depreciation		Care Centers, Inc.	100.00%	6,907	6,907
39	Total		\$ 47,124			\$ 93,168	\$ * 46,044

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32 Interest	\$	Care Centers, Inc.	100.00%	\$ 1,153	\$ 1,153	15
16	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	545	545	16
17	V	34 Rent-Building		Care Centers, Inc.	100.00%	2,582	2,582	17
18	V	35 Rent-Equipment & Auto		Care Centers, Inc.	100.00%	465	465	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 4,745	\$ * 4,745	39

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 53	Care Centers, Inc.	100.00%	\$ 53	\$	15
16	V	07 Employee Benefits - Gen Service	8	Care Centers, Inc.	100.00%	18		10 16
17	V	10 Nursing Salary	8,138	Care Centers, Inc.	100.00%	8,138		17
18	V	10a Therapy Salary		Care Centers, Inc.	100.00%			18
19	V	15 Employee Benefits - Healthcare	1,221	Care Centers, Inc.	100.00%	830		(391) 19
20	V	17 Administrative Salary		Care Centers, Inc.	100.00%			20
21	V	21 Office Salary		Care Centers, Inc.	100.00%			21
22	V	22 Employee Benefits		Care Centers, Inc.	100.00%			22
23	V	27 Employee Benefits - Gen. Admin.		Care Centers, Inc.	100.00%			23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 9,420			\$ 9,039	\$ *	(381) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$	Care Center Health System	100.00%	\$ 1,441	\$ 1,441	15
16	V	01 Dietary Other	32	Care Center Health System	100.00%	413	381	16
17	V	02 Food	65	Care Center Health System	100.00%	1,444	1,379	17
18	V	06 Maintenance		Care Center Health System	100.00%	14	14	18
19	V	07 Employee Benefits - Gen Services		Care Center Health System	100.00%	219	219	19
20	V	10 Nusing		Care Center Health System	100.00%			20
21	V	17 Administrative		Care Center Health System	100.00%	106	106	21
22	V	19 Professional Fees		Care Center Health System	100.00%	2	2	22
23	V	20 Dues & Subscriptions		Care Center Health System	100.00%	3	3	23
24	V	21 Office & Clerical Salary		Care Center Health System	100.00%			24
25	V	21 Office & Clerical Other		Care Center Health System	100.00%	243	243	25
26	V	23 Inservice & Education		Care Center Health System	100.00%			26
27	V	24 Travel & Seminar		Care Center Health System	100.00%	84	84	27
28	V	26 Insurance		Care Center Health System	100.00%	75	75	28
29	V	30 Depreciation		Care Center Health System	100.00%	40	40	29
30	V	32 Interest Expense		Care Center Health System	100.00%	135	135	30
31	V	33 Real Estate Taxes		Care Center Health System	100.00%			31
32	V	34 Rent-Building		Care Center Health System	100.00%			32
33	V	35 Rent-Equipment & Auto		Care Center Health System	100.00%	8	8	33
34	V	39 Ancillary	4,211	Care Center Health System	100.00%	2,939	(1,272)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 4,308			\$ 7,166	\$ * 2,858	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	22 Employee Health Insurance	53,929	CCS Employee Benefit Group	100.00%		(53,929)	16
17	V	22 Employee Health Insurance		CCS Employee Benefit Group	100.00%	53,929	53,929	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 53,929			\$ 53,929	\$ *	39

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item			Name of Related Organization						
15	V	30	Depreciation	\$		Vent Lease LLC	100.00%	\$ 265	\$ 265	15	
16	V	32	Interest			Vent Lease LLC	100.00%	94	94	16	
17	V	35	Rent - Equipment		720	Vent Lease LLC	100.00%		(720)	17	
18	V									18	
19	V									19	
20	V									20	
21	V									21	
22	V									22	
23	V									23	
24	V									24	
25	V									25	
26	V									26	
27	V									27	
28	V									28	
29	V									29	
30	V									30	
31	V									31	
32	V									32	
33	V									33	
34	V									34	
35	V									35	
36	V									36	
37	V									37	
38	V									38	
39	Total			\$	720			\$	359	\$ * (361)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 524	Xcel Medical Supply LLC		\$ 473	\$ (51)
16	V	2 Food	47	Xcel Medical Supply LLC		42	(5)
17	V	3 Housekeeping	7,040	Xcel Medical Supply LLC		6,342	(698)
18	V	4 Laundry	5,884	Xcel Medical Supply LLC		5,301	(583)
19	V	6 Repairs & Maintenance	526	Xcel Medical Supply LLC		474	(52)
20	V	10 Nursing	34,201	Xcel Medical Supply LLC		30,810	(3,391)
21	V	10a Therapy	10	Xcel Medical Supply LLC		9	(1)
22	V	11 Activities		Xcel Medical Supply LLC			
23	V	20 Dues, Fees, Subscriptions	530	Xcel Medical Supply LLC		478	(52)
24	V	21 Clerical & General Office		Xcel Medical Supply LLC			
25	V	22 Employee Benefits	48	Xcel Medical Supply LLC		42	(6)
26	V	39 Ancillary	13,664	Xcel Medical Supply LLC		12,309	(1,355)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 62,474			\$ 56,280	\$ * (6,194)

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

Snow Valley Nursing & Rehab Center

Provider #:

01/01/05

0046185

12/31/05

Schedule 6A

CARE CENTERS, INC.  
 SUMMARY OF NON-BUILDING RENTAL  
 RELATED ENTITIES  
 AS OF  
 December 31, 2005

	CARE CENTERS, INC.	CARE CENTERS HEALTH SYSTEMS	CCS EMPLOYEE BENEFITS GROUP	ROTHNER VENT LEASE LLC	HARBOR LIGHTS	XCEL MED. SUPPLY
<b>ILLINOIS HOMES</b>						
Applewood Nursing & Rehabilitation Center	X	X	X	X		X
Briar Place LTD.	X	X	X	X	X	X
Chateau Village Nursing & Rehabilitation Center	X	X	X	X		X
Colonial Hall Nursing & Rehabilitation Center	X	X	X	X		X
Concord Extended Care	X	X	X	X	X	X
Grasmere Place LLC	X		X			X
International Village Nursing & Rehabilitation Center	X	X	X	X		X
Lakewood Nursing & Rehabilitation Center	X	X	X	X		X
Lemont Nursing & Rehabilitation Center	X	X	X	X		X
Pavillion of Forest Park LLC	X	X	X	X	X	X
Plum Grove Nursing & Rehabilitation Center	X					X
Prairie Manor Health Care	X	X	X	X		X
Rainbow Beach Nursing Center	X		X			X
Ridgeland Nursing & Rehabilitation Center	X	X	X	X		X
Rivershores Nursing & Rehabilitation Center	X	X	X	X		X
Sheridan Shores Nursing & Rehabilitation Center	X	X	X	X		X
Snow Valley Nursing & Rehabilitation Center	X	X	X	X		X
Somerset Place LLC	X		X			X
South Shores Nursing & Rehabilitation Center	X	X	X	X		X
Tri-State Nursing & Rehabilitation Center	X	X	X	X		X
Washington Heights Nursing & Rehabilitation Center	X	X	X	X		X
Westshire Nursing & Rehabilitation Center	X	X	X			X
Wheaton Care Center, LTD	X	X	X	X	X	X
<b>INDIANA HOMES</b>						
Clark Nursing & Rehabilitation Center	X	X	X	X	X	X
Dyer Nursing & Rehabilitation Center	X	X	X	X	X	X
East Lake Nursing & Rehabilitation Center	X	X	X	X	X	X
Lake County Nursing & Rehabilitation Center	X	X	X	X	X	X
Northlake Nursing & Rehabilitation Center	X	X	X	X	X	X
Sebos, Nursing & Rehabilitation Center	X	X	X	X	X	X
Sheffield Manor	X		X			X
Valparaiso Care & Rehabilitation Center	X	X	X	X	X	X
<b>OHIO HOMES</b>						
McKinley Health Care Center	X	X	X	X		X

**Snow Valley Nursing & Rehab Center**

**Provider #: 0046185**

**01/01/05 12/31/05**

**Schedule 6B**

**RELATED NURSING HOMES**

December 31, 2005

GROUP NAME	FACILITY NAME	CITY
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**CARE CENTERS, INC.**

**ILLINOIS HOMES**

Applewood Nursing & Rehabilitation Center	MATTESON
Briar Place LTD.	INDIAN HEAD
Chateau Village Nursing & Rehabilitation Center	WILLOWBROOK
Colonial Hall Nursing & Rehabilitation Center	PRINCETON
Concord Extended Care	OAK LAWN
Grasmere Place LLC	CHICAGO
International Village Nursing & Rehabilitation Center	CHICAGO
Lakewood Nursing & Rehabilitation Center	PLAINFIELD
Lemont Nursing & Rehabilitation Center	LEMONT
Pavillion of Forest Park LLC	FOREST PARK
Plum Grove Nursing & Rehabilitation Center	PALATINE
Prairie Manor Health Care	CHICAGO HEIGHTS
Rainbow Beach Nursing Center	CHICAGO
Ridgeland Nursing & Rehabilitation Center	PALOS HEIGHTS
Rivershores Nursing & Rehabilitation Center	MARSEILLES
Sheridan Shores Nursing & Rehabilitation Center	CHICAGO
Snow Valley Nursing & Rehabilitation Center	LISLE
Somerset Place LLC	CHICAGO
South Shores Nursing & Rehabilitation Center	CHICAGO
Tri-State Nursing & Rehabilitation Center	Lansing
Washington Heights Nursing & Rehabilitation Center	CHICAGO
Westshire Nursing & Rehabilitation Center	CICERO
Wheaton Care Center, LTD	WHEATON

**INDIANA HOMES**

Clark Nursing & Rehabilitation Center	Gary
Dyer Nursing & Rehabilitation Center	Dyer
East Lake Nursing & Rehabilitation Center	Elkhardt
Lake County Nursing & Rehabilitation Center	East Chicago
Northlake Nursing & Rehabilitation Center	Merriville
Sebos, Nursing & Rehabilitation Center	Holbart
Sheffield Manor	Dyer
Valparaiso Care & Rehabilitation Center	Valparaiso

**OHIO HOMES**

McKinley Health Care Center	Canton
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**Snow Valley Nursing & Rehab Center**

**Provider #:**

**0046185**

**01/01/05**

**12/31/05**

**Schedule 6C**

**OTHER RELATED BUSINESS ENTITIES**

**AS OF**

**December 31, 2005**

NAME		CITY	TYPE OF BUSINESS
CARE CENTERS, INC.		EVANSTON, IL	MANAGEMENT COMPANY
CARE CENTERS HEALTH SYSTEM		EVANSTON, IL	DIETARY & FOOD SUPPLEMENTS
HARBOR LIGHTS	*	GLEN ELLYN	HOSPICE
ROTHNER VENTS LLC		EVANSTON, IL	MEDICAL EQUIP RENTAL
2201 MAIN, LLC		EVANSTON, IL	BUILDING COMPANY

\* - Page 6 & 8 Are not required for this entity since there was no payment from the Nursing Homes to the Related Entity

**SEE THE ATTACHED SUMMARY FOR THE APPLICABILITY OF EACH RELATED BUSINESS ENTITY TO THE RELATED NURSING HOME**

Facility Name & ID Number      Snow Valley Nursing & Rehab Center      #      0046185      Report Period Beginning:      01/01/05      Ending:      12/31/05

## 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	Eric Rothner	Relative	Administrative	0.00	See Attached	0.36	.90%	CCI -Salary	\$ 856	17-7	1
2	Adam Vales	Relative	Clerical	0.00	See Attached	0.35	.87%	CCS -VEBA	431	22-7	2
3	Mark Steinberg	Relative	Administrative	0.00	See Attached	0.62	1.55%	CCI -Salary	824	17-7	3
4	Aaron Shpayer	Owner	Administrative	0.49	See Attached			Mgmt Fees	30,000	17-7	4
5	Gale Rothner	Owner	Administrative	0.51	See Attached			Mgmt Fees	30,000	17-7	5
6	Gale Rothner	Owner	Administrative	0.51	See Attached	0.39	.97%	CCI -Salary	874	17-7	6
7	Kim Rudolph	Relative	Administrative	0.00	See Attached	0.32	.80%	CCS -VEBA	261	22-7	7
8	Kim Rudolph	Relative	Administrative	0.00	See Attached	0.32	.80%	CCI -Salary	173	17.7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 63,419		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 Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

Name of Related Organization Care Centers, Inc  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 6020  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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

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	Dietary Salary	Patient Days	32	\$ 107,276	\$ 107,276	16,772	\$ 1,202	1
2	1	Dietary Other	Patient Days	32	9,406		16,772	105	2
3	5	Utilities	Patient Days	32	59,188		16,772	663	3
4	6	Maintenance Salary	Patient Days	32	130,484	130,484	16,772	1,462	4
5	6	Maintenance Other	Patient Days	32	144,661		16,772	1,620	5
6	7	Employee Ben. - Gen. Services	Patient Days	32	34,158		16,772	383	6
7	10	Nursing Salary	Patient Days	32			16,772	0	7
8	10	Nursing Other	Patient Days	32			16,772	0	8
9	10a	Therapy Salary	Patient Days	32	14,139	14,139	16,772	158	9
10	10a	Therapy Other	Patient Days	32			16,772	0	10
11	15	Employee Ben. Healthcare	Patient Days	32	1,933		16,772	22	11
12	17	Administrative Salary	Patient Days	32	783,083	783,083	16,772	8,772	12
13	17	Administrative Other	Patient Days	32	97,000		16,772	1,087	13
14	19	Professional Fees	Patient Days	32	543,148		16,772	6,084	14
15	20	Dues & Subscriptions	Patient Days	32	127,217		16,772	1,425	15
16	21	Office & Clerical Salary	Patient Days	32	4,281,771	4,281,771	16,772	47,963	16
17	21	Office & Clerical Other	Patient Days	32	472,845		16,772	5,297	17
18	23	Inservice & Education	Patient Days	32			16,772	0	18
19	24	Travel & Seminar	Patient Days	32	123,511		16,772	1,384	19
20	25	Other Admin. Staff Transportation	Patient Days	32			16,772	0	20
21	26	Insurance	Patient Days	32	44,126		16,772	494	21
22	27	Employee Ben. - Gen. Admin	Patient Days	32	726,674		16,772	8,140	22
23	30	Depreciation	Patient Days	32	616,575		16,772	6,907	23
24	32	Interest	Patient Days	32	102,930		16,772	1,153	24
25	TOTALS				\$ 8,420,125	\$ 5,316,753		\$ 94,321	25

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

Name of Related Organization Care Centers, Inc  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 6020  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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

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	33	Real Estate Taxes	Patient Days	32	\$ 48,662	\$	16,772	\$ 545	1
2	34	Rent- Building	Patient Days	32	230,488		16,772	2,582	2
3	35	Rent - Equipment & Auto	Patient Days	32	41,530		16,772	465	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				\$ 320,680	\$		\$ 3,592	25

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

Name of Related Organization Care Centers, Inc  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 6020  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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

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	6	Maintenance Salary	Direct Cost	53	\$ 53	\$ 53	53	\$ 53	1
2	7	Emp. Ben. - Gen Services	Direct Cost	18	18		18	18	2
3	10	Nursing Salary	Direct Cost	8,138	8,138	8,138	8,138	8,138	3
4	10a	Therapy Salary	Direct Cost						4
5	15	Emp. Ben. - Healthcare	Direct Cost	830	830		830	830	5
6	17	Administrative Salary	Direct Cost						6
7	21	Office Salary	Direct Cost						7
8	22	Employee Benefits	Direct Cost						8
9	27	Emp. Ben. - Gen Admin	Direct Cost						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				\$ 9,039	\$ 8,191		\$ 9,039	25

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

Name of Related Organization Care Center Health System  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 6020  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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

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	Dietary Salary	928,452		\$ 160,568	\$ 160,568	8,331	\$ 1,441	1
2	1	Dietary Other	928,452		46,000		8,331	413	2
3	2	Food	928,452		160,931		8,331	1,444	3
4	6	Maintenance	928,452		1,614		8,331	14	4
5	7	Employee Ben. - Gen. Services	928,452		24,382		8,331	219	5
6	17	Administrative	928,452		11,797		8,331	106	6
7	19	Professional Fees	928,452		262		8,331	2	7
8	20	Dues & Subscriptions	928,452		342		8,331	3	8
9	21	Office & Clerical Salaries	928,452				8,331		9
10	21	Office & Clerical Other	928,452		27,087		8,331	243	10
11	23	Inservices & Education	928,452				8,331		11
12	24	Travel & Seminar	928,452		9,381		8,331	84	12
13	25	Other Admin. Staff Transport.	928,452				8,331		13
14	26	Insurance	928,452		8,379		8,331	75	14
15	27	Employee Ben. - Gen. Admin	928,452				8,331		15
16	30	Depreciation	928,452		4,499		8,331	40	16
17	32	Interest	928,452		15,077		8,331	135	17
18	33	Real Estate Taxes	928,452				8,331		18
19	34	Rent- Building	928,452				8,331		19
20	35	Rent - Equipment & Auto	928,452		843		8,331	8	20
21	39	Ancillary Enteral Supplies	928,452		327,517		8,331	2,939	21
22									22
23									23
24									24
25	TOTALS				\$ 798,679	\$ 160,568		\$ 7,166	25

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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

Name of Related Organization CCS Employee Benefits Group, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 6020  
 Phone Number ( 847) 905-4000  
 Fax Number ( 847) 905-4040

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

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	22	Employee Health Insurance	53,929		53,929		53,929	53,929	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				\$ 53,929	\$		\$ 53,929	25

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

Name of Related Organization Vent Lease, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 6020  
 Phone Number ( 847) 905-4000  
 Fax Number ( 847) 905-4040

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

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	30 Depreciation	Direct Billing	593,410	29	\$ 197,493	\$	795	\$ 265	1
2	32 Interest	Direct Billing	593,410	29	69,863		795	94	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				\$ 267,356	\$		\$ 359	25

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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

Name of Related Organization Xcel Medical Supply, LLC  
 Street Address 2201 West Main street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847 ) 328-7600  
 Fax Number ( 847 ) 328-7615

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

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	Dietary			\$	\$		473	1
2	2	Food						42	2
3	3	Housekeeping						6,342	3
4	4	Laundry						5,301	4
5	6	Repairs & Maintenance						474	5
6	10	Nursing						30,810	6
7	10a	Therapy						9	7
8	11	Activities							8
9	20	Dues, Fees, Subscriptions						478	9
10	21	Clerical & General Office							10
11	22	Employees Benefits						42	11
12	39	Ancillary						12,309	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				\$	\$		56,280	25

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	LaSalle Bank		X	Mortgage			\$	938,075			\$ 46,288	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	LaSalle Bank		X	Line of Credit				65,000			4,284	6
7	Allocated from Care Centers		X									7
8	See Sch. 9A										1,382	8
9	TOTAL Facility Related						\$	1,003,075			\$ 51,954	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income										(64)	10
11												11
12												12
13	See Schedule 9A											13
14	TOTAL Non-Facility Related						\$				\$ (64)	14
15	TOTALS (line 9+line14)						\$	1,003,075			\$ 51,890	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* 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 Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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		8	9	10				
						Amount of Note						Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
						Original	Balance							
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note									
	YES	NO												
<b>A. Directly Facility Related</b>														
<b>Long-Term</b>														
1						\$	\$			\$	1			
2											2			
3											3			
4											4			
5											5			
<b>Working Capital</b>														
6	Allocated from Care Centers										1,153	6		
7	Allocated from Vent Lease										94	7		
8	Allocated from CCHS										135	8		
9	<b>TOTAL Facility Related</b>					\$	0	\$	0		\$	1,382	9	
<b>B. Non-Facility Related*</b>														
10	Shareholders	X										10		
11												11		
12												12		
13												13		
14	<b>TOTAL Non-Facility Related</b>					\$	0	\$	0		\$	0	14	
15	<b>TOTALS (line 9+line14)</b>					\$	0	\$	0		\$	1,382	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* 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.)



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Snow Valley Nursing & Rehab Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0046185

CONTACT PERSON REGARDING THIS REPORT Mike Kaplan

TELEPHONE (847) 905-4042 FAX #: (847) 905-3030

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 08-10-220-006	Long Term Care Property	\$ 16,158.10	\$ 16,158.10
2. See Attached Schedule	Home Office Allocation	\$ 48,662.44	\$ 545.10
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>64,820.54</u>	\$ <u>16,703.20</u>

**B. Real Estate Tax Cost Allocation:**

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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

A. Square Feet: 12,019 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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  NO  
 If so, please complete the following:  
 1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_  
 Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	100,500	2003	\$ 139,765	1
2	2201 Main LLC			3,940	2
3	TOTALS			\$ 143,705	3

Facility Name & ID Number Snow Valley Nursing & Rehab Center

# 0046185

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	51	2003		\$ 1,243,335		40	\$ 31,083	\$ 31,083	\$ 90,659	4
5										5
6										6
7										7
8										8
Improvement Type**										
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17	2201 Main LLC Allocation Building		2002	5,429		20	139	139	458	17
18	2201 Main LLC Allocation Building Improvement:		2002	4,485		20	224	224	785	18
19	2201 Main LLC Allocation Building Improvement:		2003	5,285		20	264	264	661	19
20	2201 Main LLC Allocation Building Improvement:		2005	263		20	6	6	6	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

\*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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,258,797	\$		\$ 31,716	\$ 31,716	\$ 92,569	70

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

STATE OF ILLINOIS

Facility Name & ID Number Snow Valley Nursing & Rehab Center

# 0046185

Report Period Beginning:

01/01/05

Ending:

Page 12B

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 1,258,797	\$		\$ 31,716	\$ 31,716	\$ 92,569		1
2	Parking Lot Repair	2003 1,388		20	69	69	174		2
3	Window Replacement	2003 8,400	840	20	420	(420)	910		3
4	Installation of Chemical System	2004 2,185	219	20	109	(110)	219		4
5	Installation of Chemical System Sales Tax	2004 138	14	20	7	(7)	13		5
6	Electric Repairs	2004 1,532	153	20	77	(76)	108		6
7	Interior Design Fees	2004 2,400	240	20	120	(120)	160		7
8	Air Conitioner Repair	2004 791		20	79	79	125		8
9	Replace Door Switches	2004 629		20	63	63	89		9
10	Wiring in New Call Station	2004 594		20	59	59	74		10
11	Carpeting	2005 42,808	1,427	15	1,426	(1)	1,426		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)	\$ 1,319,662	\$ 2,893		\$ 34,145	\$ 31,252	\$ 95,867		34

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 126,059	\$ 3,573	\$ 24,534	\$ 20,961	10	\$ 80,428	71
72	Current Year Purchases	3,933		110	110	10	110	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 129,992	\$ 3,573	\$ 24,644	\$ 21,071		\$ 80,538	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Allocated from Care Centers			7,564		554	554	5	5,728	77
78										78
79										79
80	TOTALS			\$ 7,564	\$	\$ 554	\$ 554		\$ 5,728	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)	\$ 1,600,923	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,466	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,343	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 52,877	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 182,133	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

**Snow Valley Nursing & Rehab Center**  
**Moveable Equipment Schedule**  
 1/1/05-12/31/05  
 0046185

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
<b>Line 28: Prior Years</b>					
Snow Valley Nursing & Rehab. Center	18,668	3,573	3,163	(410)	5,463
Snow Valley Properties LLC	78,859		15,456	15,456	55,674
2201 West Main LLC	1,256		179	179	633
Care Centers, Inc	27,276		5,431	5,431	18,658
Vent Lease			265	265	
Care Centers Health System			40	40	
<b>Total</b>	<b>126,059</b>	<b>3,573</b>	<b>24,534</b>	<b>20,961</b>	<b>80,428</b>

**Line 29: Current Year**

Snow Valley Nursing & Rehab. Center					
Snow Valley Properties LLC					
2201 West Main LLC	253		17	17	17
Care Centers, Inc	3,680		93	93	93
Vent Lease					
Care Centers Health System					
<b>Total</b>	<b>3,933</b>		<b>110</b>	<b>110</b>	<b>110</b>

**Line 30: Fully Depreciated**

Snow Valley Nursing & Rehab. Center					
Snow Valley Properties LLC					
2201 West Main LLC					
Care Centers, Inc					
Vent Lease					
Care Centers Health System					
<b>Total</b>					

**Total (Should tie to page 13)**

Snow Valley Nursing & Rehab. Center	18,668	3,573	3,163	(410)	5,463
Snow Valley Properties LLC	78,859		15,456	15,456	55,674
2201 West Main LLC	1,509		196	196	650
Care Centers, Inc	30,956		5,524	5,524	18,751
Vent Lease			265	265	
Care Centers Health System			40	40	
<b>Total</b>	<b>129,992</b>	<b>3,573</b>	<b>24,644</b>	<b>21,071</b>	<b>80,538</b>

**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?  YES  NO  
If NO, see instructions.

		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	Allocated from Care Centers				2,582			6
7	TOTAL				\$ 2,582			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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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 N/A.

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

**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: \$ 3,106 Description: \$ 2,411 Copier Machine, \$222 Postage Meter, \$473 Care centers, Inc  
(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		<u>N/A</u>			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.

**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?                  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.</p>	<p><input type="checkbox"/> YES  <input checked="" type="checkbox"/> NO</p>	<p>2. <b>CLASSROOM PORTION:</b>                  IN-HOUSE PROGRAM <input type="checkbox"/>                  IN OTHER FACILITY <input type="checkbox"/>                  COMMUNITY COLLEGE <input type="checkbox"/>                  HOURS PER CNA _____</p>	<p>3. <b>CLINICAL PORTION:</b>                  IN-HOUSE PROGRAM <input type="checkbox"/>                  IN OTHER FACILITY <input type="checkbox"/>                  HOURS PER CNA _____</p>
--	---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	L. 10a, C. 3	hrs	\$		\$	18,919	\$			\$	18,919	1	
2	Licensed Speech and Language Development Therapist	L.10a, C.3	hrs				17,137					17,137	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	L.10a, C.3	hrs				40,119					40,119	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	L. 39, C. 2	# of prescripts							55,419			55,419	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify): See Sch 16a						0			16,948			16,948	13
14	TOTAL			\$		\$	76,175	\$	72,367		\$	148,542	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.

**Snow Valley Nursing & Rehab Center**

**Provider #: 0046185**

**01/01/05 to 12/31/05**

**Schedule 16A**

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner</u>		<u>Supplies</u>
		<u>Units</u>	<u>Cost</u>	
Therapy and Rehab. Supplies	L10a C 2			109
Medical Supplies	L 39 C 2			14,516
Air Fluidized Beds	L 39 C 2			1,304
Oxygen	L 39 C 2			46
Wheelchairs and Walkers	L 39 C 2			336
Other Services	L 39 C 2			637
Total		<u>0</u>	<u>0</u>	<u>16,948</u>

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Snow Valley Nursing &amp; Rehab Center

# 0046185

Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 500	\$ 500	1
2	Cash-Patient Deposits	11,796	11,796	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 30,000 )	298,340	298,340	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,868	7,868	6
7	Other Prepaid Expenses	12,768	12,768	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 331,272	\$ 331,272	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,705	13
14	Buildings, at Historical Cost		1,258,797	14
15	Leasehold Improvements, at Historical Cost	57,463	60,865	15
16	Equipment, at Historical Cost	18,668	137,556	16
17	Accumulated Depreciation (book methods)	(10,877)	(182,133)	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): See Sch 17A		196,019	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 65,254	\$ 1,614,809	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 396,526	\$ 1,946,081	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 82,248	\$ 82,248	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,976	10,976	28
29	Short-Term Notes Payable	65,000	65,000	29
30	Accrued Salaries Payable	83,531	83,531	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,860	4,860	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,000	17,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Sch 17A	37,318	37,318	36
37	See Sch 17A	31,210	31,210	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 332,143	\$ 332,143	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		938,075	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 938,075	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 332,143	\$ 1,270,218	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 64,383	\$ 675,863	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 396,526	\$ 1,946,081	48

\*(See instructions.)

Snow Valley Nursing & Rehab Center  
 0046185  
 12/31/05

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

Other Current Assets (specify):	Operating	After Consolidation
Total Line 9 - Other Current Assets(specify):	<b>0</b>	<b>0</b>

B. Long Term Assets

Other Long Term Assets (specify):	Operating	After Consolidation
Goodwill		201,342
Amortization of Goodwill		(14,843)
Financing Fees		23,105
Amortization of Financing Fees		(13,585)
Total Line 23 - Other Long Term Assets Assets(spec	<b>0</b>	<b>196,019</b>

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Accrued Expenses	36,504	36,504
Due to Medicaid	814	814
Total Line 36 - Other Current Liabilities(specify):	<b>37,318</b>	<b>37,318</b>

Other Current Liabilities (specify):

Other Long Term Assets (specify):	Operating	After Consolidation
Due to Others	17,236	17,236
Due to Prior Owners	13,974	13,974
Total Line 37 - Other Current Liabilities(specify):	<b>31,210</b>	<b>31,210</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 224,910	1
2	Restatements (describe):		2
3			3
4	Year End Review Adjustment From FR&R -	(69,538)	4
5	See Attach Schedule		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 155,372	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(50,189)	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	(40,800)	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)	\$ (90,989)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 64,383	24 *

Operating Entity Only

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

STATE OF ILLINOIS

Facility Name & ID Number Snow Valley Nursing & Rehab Center

# 0046185

Report Period Beginning: 01/01/05

Ending:

Page 19  
12/31/05

**VII. 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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,386,007	1
2	Discounts and Allowances for all Levels	(344,175)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,041,832	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	288,706	6
7	Oxygen	152	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 288,858	8
<b>C. Other Operating Revenue</b>			
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	7,140	13
14	Non-Patient Meals	614	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,243	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,818	19
20	Radiology and X-Ray	2,670	20
21	Other Medical Services	69,078	21
22	Laundry	5,684	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 155,247	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	64	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 64	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Sch 19A</u>	478	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 478	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,486,479	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	422,164	31
32	Health Care	1,168,023	32
33	General Administration	642,423	33
<b>B. Capital Expense</b>			
34	Ownership	183,695	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	92,440	35
36	Provider Participation Fee	27,923	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,536,668	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(50,189)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (50,189)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

Snow Valley Nursing & Rehab Center  
0046185  
12/31/05

Schedule 19A

XVII. INCOME STATEMENT

Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Vending Income	476
Other Income	2
	<hr/>
<b>Total Line 28 - Other Revenue (specify):</b>	<b><u><u>478</u></u></b>

Facility Name &amp; ID Number Snow Valley Nursing &amp; Rehab Center

# 0046185

Report Period Beginning: 01/01/05

Ending: 12/31/05

## 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	1,667	1,769	\$ 53,685	\$ 30.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,767	7,305	196,243	26.86	3
4	Licensed Practical Nurses	8,075	8,711	202,535	23.25	4
5	CNAs & Orderlies	27,105	29,078	393,699	13.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,850	2,082	31,925	15.33	9
10	Activity Assistants					10
11	Social Service Workers	141	67	1,820	27.16	11
12	Dietician					12
13	Food Service Supervisor	1,862	2,078	31,137	14.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,719	3,024	36,020	11.91	15
16	Dishwashers	4,657	4,886	45,530	9.32	16
17	Maintenance Workers	1,907	2,171	47,962	22.09	17
18	Housekeepers	4,835	4,979	38,973	7.83	18
19	Laundry	3,020	3,394	30,005	8.84	19
20	Administrator	1,841	2,297	89,417	38.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,747	4,057	77,995	19.22	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 C: See Sch20A	6,519	7,209	143,481	19.90	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	76,712	83,107	\$ 1,420,427 *	\$ 17.09	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	132	\$ 6,073	L.1 C. 3	35
36	Medical Director	Monthly	8,400	L.9 C. 3	36
37	Medical Records Consultant	Monthly	248	L.10 C. 3	37
38	Nurse Consultant	47	3,196	L.10 C. 3	38
39	Pharmacist Consultant	Monthly	1,718	L.10 C. 3	39
40	Physical Therapy Consultant			L.10a C. 3	40
41	Occupational Therapy Consultant			L.10a C. 3	41
42	Respiratory Therapy Consultant			L.10a C. 3	42
43	Speech Therapy Consultant			L.10a C. 3	43
44	Activity Consultant	16	784	L.11 C. 3	44
45	Social Service Consultant			L.12 C. 3	45
46	Other(specify)				46
47	Therapy Program Consultant	1	24	L.10a C. 3	47
48	CCI Consultants See Sch 20B				48
49	TOTAL (lines 35 - 48)	196	\$ 20,443		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ N/A	L. 10 C. 3	50
51	Licensed Practical Nurses		L. 10 C. 3	51
52	Certified Nurse Assistants/Aides		L. 10 C. 3	52
53	TOTAL (lines 50 - 52)	\$		53

Snow Valley Nursing & Rehab Center  
 0046185  
 12/31/05

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Ward Clerk	2,174	2,223	\$ 39,474	17.76
Rehab Nurse	164	205	\$ 4,559	22.24
Rehab Aides	2,540	2,884	49,896	17.30
Care Plan Coord.	1,641	1,897	49,552	26.12
<b>Total Line 32 - Other</b>	<b>6,519</b>	<b>7,209</b>	<b>\$ 143,481</b>	<b>\$ 19.90</b>

XVIII. STAFFING AND SALARY COSTS

LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
				#DIV/0!
				#DIV/0!
				#DIV/0!
<b>Total Line 33 - Other</b>	<b>0</b>	<b>0</b>	<b>\$ -</b>	<b>#DIV/0!</b>

Snow Valley Nursing & Rehab Center  
0046185  
12/31/05

Schedule 20B

XVIII. Consultant Services  
LINE 46

	# of Hrs. Reporting Period		Schedule V
	Actually	Total Consultant	Line &
	Worked	Costs	Column
Care Plan Coord.	252	\$ 8,138	L 10 C 3
Maintenance	3	53	L 6 C 3
<b>Total Line 46 - Other</b>	<b>255</b>	<b>\$ 8,191</b>	

Facility Name & ID Number Snow Valley Nursing & Rehab Center

# 0046185

Report Period Beginning: 01/01/05

Ending: 12/31/05

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
Sandra C Larson	Administrator	0	89,417	Workers' Compensation Insurance	46,231	IDPH License Fee	580
				Unemployment Compensation Insurance	28,803	Advertising: Employee Recruitment	15,965
				FICA Taxes	105,233	Health Care Worker Background Check (Indicate # of checks performed <u>27</u> )	593
				Employee Health Insurance	26,650	Illinois Council on Long Term Care	2,968
				Employee Meals		Various Dues	1,270
				Illinois Municipal Retirement Fund (IMRF)*		Various Subscriptions	229
				Employee Physical	300	Various License	1,149
				Other Employee Benefits	6,583	Bldg Co. Fees	250
				Holiday Expense	1,267	Allocated from Care Centers	1,428
						Less: Public Relations Expense	( )
						Non-allowable advertising	( )
						Yellow page advertising	( )
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 89,417	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)	
				\$ 215,067		\$ 24,432	
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
Gale Rothner		30,000				Out-of-State Travel	
Aron Shpayher		30,000					
Care Centers, Home Office & Bookkeeping Services		47,124				In-State Travel	
Care Centers Services were Eliminated in Col 7			N/A				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$ 107,124				Seminar Expense	2,312
						Allocation From Care Centers	1,468
						Entertainment Expense	( )
						(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 41,523	TOTAL		\$ 3,780	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Snow Valley Nursing & Rehab Center**

**Provider #: 0046185**

**01/01/05 to 12/31/05**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	41,523
Allocated from Management Company	7,173
Disallow 2004 Legal Bills Winston & Strawn	(7,500)
Total (agree to Schedule V, line 19, column 8)	<u>41,196</u>



Facility Name & ID Number Snow Valley Nursing & Rehab Center# 0046185Report Period Beginning: 01/01/05Ending: 12/31/05

## 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. Illinois Council on Lon Term Care \$2,968
- (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? \_\_\_\_\_
- (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? 0
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,979 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. \$ 27,923  
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. \$ 614
- (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. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
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. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	112,687	8,117	6,073	126,877	0	126,877	3,078	129,955
2. Food Purchase	0	88,701	0	88,701	0	88,701	284	88,985
3. Housekeeping	38,973	8,733	5,872	53,578	0	53,578	(698)	52,880
4. Laundry	30,005	10,047	0	40,052	0	40,052	(583)	39,469
5. Heat and Other Utilities	0	0	38,114	38,114	0	38,114	663	38,777
6. Maintenance	47,962	0	26,872	74,834	0	74,834	3,044	77,878
7. Other (specify)*	0	0	8	8	0	8	612	620
8. Total General Services	229,627	115,598	76,939	422,164	0	422,164	6,400	428,564
9. Medical Director	0	0	8,400	8,400	0	8,400	0	8,400
10. Nursing & Medical Records	989,643	41,621	13,300	1,044,564	0	1,044,564	(3,391)	1,041,173
10a. Therapy	0	109	76,200	76,309	0	76,309	157	76,466
11. Activities	31,925	3,000	784	35,709	0	35,709	0	35,709
12. Social Services	1,820	0	0	1,820	0	1,820	0	1,820
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	1,221	1,221	0	1,221	(369)	852
16. Total Health Care & Programs	1,023,388	44,730	99,905	1,168,023	0	1,168,023	(3,603)	1,164,420
17. Administrative	89,417	0	107,124	196,541	0	196,541	(38,246)	158,295
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	41,523	41,523	0	41,523	(327)	41,196
20. Fees, Subscriptions & Promotion	0	0	22,806	22,806	0	22,806	1,626	24,432
21. Clerical & General Office	77,995	12,482	22,162	112,639	0	112,639	53,748	166,387
22. Employee Benefits & Payroll	0	0	215,073	215,073	0	215,073	(6)	215,067
23. Inservice Training & Education	0	0	699	699	0	699	0	699
24. Travel and Seminar	0	0	2,312	2,312	0	2,312	1,468	3,780
25. Other Admin. Staff Trans	0	0	2,649	2,649	0	2,649	0	2,649
26. Insurance-Prop.Liab.Malpractice	0	0	48,181	48,181	0	48,181	569	48,750
27. Other (specify)*	0	0	0	0	0	0	8,140	8,140
28. Total General Adminis	167,412	12,482	462,529	642,423	0	642,423	26,972	669,395
29. Total General Administrative	1,420,427	172,810	639,373	2,232,610	0	2,232,610	29,769	2,262,379
30. Depreciation	0	0	6,466	6,466	0	6,466	52,877	59,343
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	4,284	4,284	0	4,284	47,606	51,890
33. Real Estate	0	0	17,259	17,259	0	17,259	545	17,804
34. Rent - Facility & Grounds	0	0	152,333	152,333	0	152,333	(149,751)	2,582
35. Rent - Equipment & Vehicles	0	0	3,353	3,353	0	3,353	(247)	3,106
36. Other (specify):*	0	0	0	0	0	0	4,570	4,570
37. Total Ownership	0	0	183,695	183,695	0	183,695	(44,400)	139,295
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	74,885	0	74,885	0	74,885	(2,627)	72,258
40. Barber and Beauty Shop	0	0	4,493	4,493	0	4,493	0	4,493
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	27,923	27,923	0	27,923	0	27,923
43. Other (specify):*	0	0	13,062	13,062	0	13,062	(13,062)	0
44. Total Special Cost Ce	0	74,885	45,478	120,363	0	120,363	(15,689)	104,674
45. Grand Total	1,420,427	247,695	868,546	2,536,668	0	2,536,668	(30,320)	2,506,348

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	500	500
2. Cash - Patient Deposits	11,796	11,796
3. Accounts & Notes Recievable	298,340	298,340
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	7,868	7,868
7. Other Prepaid Expenses	12,768	12,768
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	331,272	331,272
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	143,705
14. Buildings, at Historical Cost	0	1,258,797
15. Leasehold Improvements, Historical Cost	57,463	60,865
16. Equipment, at Historical Cost	18,668	137,556
17. Accumulated Depreciation (book methods)	-10,877	-182,133
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	196,019
24. Total Long-Term Assets	65,254	1,614,809
25. Total Assets	396,526	1,946,081
CURRENT LIABILITIES		
26. Accounts Payable	82,248	82,248
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	10,976	10,976
29. Short-Term Notes Payable	65,000	65,000
30. Accrued Salaries Payable	83,531	83,531
31. Accrued Taxes Payable	4,860	4,860
32. Accrued Real Estate Taxes	17,000	17,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	37,318	37,318
37. Other Current Liabilities (specify):	31,210	31,210
38. Total Current Liabilities	332,143	332,143
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	938,075
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	938,075
46. Total Liabilities	332,143	1,270,218
47. Total Equity	64,383	675,863
48. Total Liabilities and Equity	396,526	1,946,081

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,386,007
2. Discounts and Allowances for all Levels	-344,175
Subtotal - Inpatient Care	2,041,832
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	288,706
7. Oxygen	152
Subtotal - Ancillary Revenue	288,858
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	7,140
14. Non-Patient Meals	614
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	49,243
18. Sale of Supplies to Non-Patients	0
19. Laboratory	20,818
20. Radiology and X-Ray	2,670
21. Other Medical Services	69,078
22. Laundry	5,684
Subtotal - Other Operating Revenue	155,247
24. Contributions	0
25. Interest and Other Investments Income	64
Subtotal - Non-Operating Revenue	64
27. Other Revenue (specify):	478
28. Other Revenue (specify):	0
Subtotal - Other Revenue	478
30. Total Revenue	2,486,479
31. General Services	396,770
32. Health Care	1,170,507
33. General Administration	578,394
34. Ownership	175,741
35. Special Cost Centers	76,843
35. Provider Participation Fee	28,000
37. Other	0
40. Total Expenses	2,426,255
41. Income Before Income Taxes	60,224
42. Income Taxes	0
43. Net Income or Loss for the Year	60,224

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