

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	<u>51</u>	Skilled (SNF)	<u>51</u>	<u>18,615</u>	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	<u>51</u>	TOTALS	<u>51</u>	<u>18,615</u>	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>9,619</u>	<u>4,727</u>	<u>2,370</u>	<u>16,716</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,619</u>	<u>4,727</u>	<u>2,370</u>	<u>16,716</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.80%

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

26 (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

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 2,178

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	124,991	19,435	5,069	149,495		149,495	(407)	149,088		1
2	Food Purchase		80,698		80,698		80,698	(956)	79,742		2
3	Housekeeping	57,895	10,583		68,478		68,478	(620)	67,858		3
4	Laundry	24,777	13,017		37,794		37,794		37,794		4
5	Heat and Other Utilities			52,556	52,556		52,556	875	53,431		5
6	Maintenance	54,728		36,622	91,350		91,350	16,661	108,011		6
7	Other (specify):*							2,313	2,313		7
8	TOTAL General Services	262,391	123,733	94,247	480,371		480,371	17,865	498,236		8
	B. Health Care and Programs										
9	Medical Director			9,500	9,500		9,500		9,500		9
10	Nursing and Medical Records	942,896	41,947	21,684	1,006,527		1,006,527	4,808	1,011,335		10
10a	Therapy	68,207		84	68,291		68,291	747	69,038		10a
11	Activities	38,790	6,248	1,188	46,226		46,226		46,226		11
12	Social Services	65,424		618	66,042		66,042	2,172	68,214		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							1,397	1,397		15
16	TOTAL Health Care and Programs	1,115,317	48,195	33,074	1,196,586		1,196,586	9,124	1,205,710		16
	C. General Administration										
17	Administrative	75,398			75,398		75,398	22,771	98,169		17
18	Directors Fees										18
19	Professional Services			142,883	142,883		142,883	(114,550)	28,333		19
20	Dues, Fees, Subscriptions & Promotions			47,049	47,049		47,049	(13,549)	33,500		20
21	Clerical & General Office Expenses	51,857	9,011	105,145	166,013		166,013	(4,717)	161,296		21
22	Employee Benefits & Payroll Taxes			250,402	250,402		250,402	(4,533)	245,869		22
23	Inservice Training & Education			2,585	2,585		2,585		2,585		23
24	Travel and Seminar			868	868		868	1,012	1,880		24
25	Other Admin. Staff Transportation			1,887	1,887		1,887	496	2,383		25
26	Insurance-Prop.Liab.Malpractice			49,843	49,843		49,843	1,146	50,989		26
27	Other (specify):*							12,534	12,534		27
28	TOTAL General Administration	127,255	9,011	600,662	736,928		736,928	(99,390)	637,538		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,504,963	180,939	727,983	2,413,885		2,413,885	(72,400)	2,341,485		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center #0046185 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			20,418	20,418	20,418	45,260	65,678			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			19,010	19,010	19,010	75,245	94,255			32
33	Real Estate Taxes			18,401	18,401	18,401	828	19,229			33
34	Rent-Facility & Grounds			153,203	153,203	153,203	(152,197)	1,006			34
35	Rent-Equipment & Vehicles			3,318	3,318	3,318	790	4,108			35
36	Other (specify):*						6,016	6,016			36
37	TOTAL Ownership			214,350	214,350	214,350	(24,058)	190,292			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		99,247	149,030	248,277	248,277	(15,800)	232,477			39
40	Barber and Beauty Shops			384	384	384	(384)				40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			27,922	27,922	27,922		27,922			42
43	Other (specify):*						19,205	19,205			43
44	TOTAL Special Cost Centers		99,247	177,336	276,583	276,583	3,021	279,604			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,504,963	280,186	1,119,669	2,904,818	2,904,818	(93,437)	2,811,381			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/07

Ending:

12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(265)	02		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	2,562	30		9
10	Interest and Other Investment Income	(2,732)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(224)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,966)	21		24
25	Fund Raising, Advertising and Promotional	(15,076)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(36,244)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,945)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(16,491)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (16,491)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (93,437)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
1 Misc Income	(459)	21 1
2 Barber and Beauty Shop	(384)	49 2
3 Annual Report	(250)	20 3
4 Theft Loss	(800)	21 4
5 Collection Expenses	(137)	21 5
6 Vending Income	(553)	02 6
7 Building Co.-Bank Charges	(14)	21 7
8 Building Co.-Replacement Tax	(750)	43 8
9 Building Co.-Filing Fees	(283)	21 9
10 Building Co.-Legal Fees	(1,102)	19 10
11 Non-Allowable Legal	(1,131)	19 11
12 COPIES Dues	(384)	20 12
13 Non-Allowable Expenses	(30,000)	21 13
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101 Total	(36,244)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	
	A. General Services													
1	Dietary			70	994	(1,426)			(45)				(407)	1
2	Food Purchase	(1,042)		86									(956)	2
3	Housekeeping			132	13	7			(772)				(620)	3
4	Laundry													4
5	Heat and Other Utilities			628	34	213							875	5
6	Maintenance			16,474	4	87		119	(23)				16,661	6
7	Other (specify):*			2,219	94								2,313	7
8	TOTAL General Services	(1,042)		19,609	1,139	(1,119)		119	(840)				17,865	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				7,725	(6)			(2,911)				4,808	10
10a	Therapy				747								747	10a
11	Activities													11
12	Social Services				2,172								2,172	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				1,397								1,397	15
16	TOTAL Health Care and Programs				12,041	(6)			(2,911)				9,124	16
	C. General Administration													
17	Administrative			2,996	13,569	1,743	4,463						22,771	17
18	Directors Fees													18
19	Professional Services	(2,233)	1,102	(86,604)	(27,089)	23	251						(114,550)	19
20	Fees, Subscriptions & Promotions	(15,707)		1,809	8	132	209						(13,549)	20
21	Clerical & General Office Expenses	(56,659)	297	44,489	3,512	2,920	1,530	(806)					(4,717)	21
22	Employee Benefits & Payroll Taxes			(4,360)	(43)				(130)				(4,533)	22
23	Inservice Training & Education													23
24	Travel and Seminar			306	163		543						1,012	24
25	Other Admin. Staff Transportation			396		100							496	25
26	Insurance-Prop.Liab.Malpractice			401	4	192	549						1,146	26
27	Other (specify):*			8,989	2,307	696	542						12,534	27
28	TOTAL General Administration	(74,599)	1,399	(31,578)	(7,569)	5,806	8,087	(806)	(130)				(99,390)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,641)	1,399	(11,969)	5,611	4,681	8,087	(687)	(3,881)				(72,400)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	2,562	35,787	5,118	215	150	292	1,136					45,260	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,732)	64,069	9,658	926	250	2,718	356					75,245	32
33	Real Estate Taxes			749	51	28							828	33
34	Rent-Facility & Grounds		(153,203)	809		197							(152,197)	34
35	Rent-Equipment & Vehicles			107	2	48	633						790	35
36	Other (specify):*		6,016										6,016	36
37	TOTAL Ownership	(170)	(47,331)	16,441	1,194	673	3,643	1,492					(24,058)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(3,119)	(8,679)	(2,975)	(1,027)				(15,800)	39
40	Barber and Beauty Shops	(384)											(384)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(750)	750				19,205						19,205	43
44	TOTAL Special Cost Centers	(1,134)	750			(3,119)	10,526	(2,975)	(1,027)				3,021	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(76,945)	(45,182)	4,472	6,805	2,235	22,256	(2,170)	(4,908)				(93,437)	45

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/07

Ending:

12/31/07

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
See Attached		See Attached		See Attached		
				Snow Valley Property, LLC		Old Building Co.
				Snow Valley Healthcare Properties, LLC		New Building Co.

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	34 Rental Income	\$ 123,510	Snow Valley Properties, LLC	100.00%	\$	\$ (123,510)	1
2	V	34 Rental Income	29,693	Snow Valley Healthcare Properties, LLC	100.00%		(29,693)	2
3	V	33 Real Estate Taxes	3,505	Snow Valley Properties, LLC	100.00%	3,505		3
4	V	33 Real Estate Taxes	14,896	Snow Valley Healthcare Properties, LLC	100.00%	14,896		4
5	V	21 Bank Charges		Snow Valley Properties, LLC	100.00%	14		5
6	V	21 Filing Fees		Snow Valley Properties, LLC	100.00%	283		6
7	V	43 State Replacement Tax		Snow Valley Properties, LLC	100.00%	750		7
8	V	19 Legal Fees		Snow Valley Properties, LLC	100.00%	1,102		8
9	V	30 Depreciation		Snow Valley Properties, LLC	100.00%	35,787		9
10	V	36 Amortization		Snow Valley Properties, LLC	100.00%	4,949		10
11	V	36 Amortization		Snow Valley Healthcare Properties, LLC	100.00%	1,067		11
12	V	32 Interest Expenses		Snow Valley Properties, LLC	100.00%	16,992		12
13	V	32 Interest Expenses		Snow Valley Healthcare Properties, LLC	100.00%	47,077		13
14	Total		\$ 171,604			\$ 126,422	\$ * (45,182)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	01	Dietary		Care Centers, Inc.	100.00%	\$ 70	\$ 70	15	
16	V	02	Food		Care Centers, Inc.	100.00%	86	86	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	132	132	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	628	628	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	1,035	1,035	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	627	627	20	
21	V	19	Professional Fees	89,914	Care Centers, Inc.	100.00%	3,310	(86,604)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	1,809	1,809	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	5,243	5,243	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	306	306	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	396	396	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	401	401	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	5,118	5,118	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	9,658	9,658	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	749	749	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	809	809	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	107	107	31	
32	V	06	Maintenance	136	Care Centers, Inc.	100.00%	15,575	15,439	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	2,219	2,219	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	2,369	2,369	34	
35	V	21	Office and Clerical	15,627	Care Centers, Inc.	100.00%	54,873	39,246	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	8,989	8,989	36	
37	V	22	Employee Benefits	4,360	Care Centers, Inc.	100.00%		(4,360)	37	
38	V								38	
39	Total			\$ 110,037			\$ 114,509	\$ * 4,472	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	03	Housekeeping		Care Centers Clinical, Inc.	100.00%	\$ 13	\$ 13	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	34	34	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	4	4	17	
18	V	19	Professional Fees	27,655	Care Centers Clinical, Inc.	100.00%	566	(27,089)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	8	8	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	33	33	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	163	163	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	4	4	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	215	215	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	926	926	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	51	51	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	2	2	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	994	994	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	94	94	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	7,725	7,725	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	747	747	30	
31	V	12	Social Service Salary	288	Care Centers Clinical, Inc.	100.00%	2,460	2,172	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	1,397	1,397	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	13,569	13,569	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	3,479	3,479	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	2,307	2,307	35	
36	V	22	Employee Benefits	43	Care Centers Clinical, Inc.	100.00%		(43)	36	
37	V								37	
38	V								38	
39	Total			\$ 27,986			\$ 34,791	\$ * 6,805	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,061	\$ 1,061	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%	7	7	16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	213	213	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	87	87	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	23	23	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	132	132	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	455	455	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	100	100	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	192	192	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	150	150	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	250	250	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	28	28	26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	197	197	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	48	48	28
29	V	01 Dietary	3,702	Care Centers Health Systems, Inc.	100.00%	1,215	(2,487)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing	9	Care Centers Health Systems, Inc.	100.00%	3	(6)	32
33	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	4,643	Care Centers Health Systems, Inc.	100.00%	1,524	(3,119)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	1,743	1,743	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,465	2,465	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	696	696	38
39	Total		\$ 8,354			\$ 10,589	\$ *	2,235 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center# 0046185Report Period Beginning: 01/01/07Ending: 12/31/07

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	17	Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 312	\$ 312	15	
16	V	19	Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	251	251	16	
17	V	20	Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	209	209	17	
18	V	21	Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	1,530	1,530	18	
19	V	24	Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	543	543	19	
20	V	26	Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	549	549	20	
21	V	30	Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	292	292	21	
22	V	32	Interest		Therapy Works Rehabilitation Services, LLC	100.00%	2,718	2,718	22	
23	V	35	Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	633	633	23	
24	V	39	Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	7,330	7,330	24	
25	V	17	Administrative		Therapy Works Rehabilitation Services, LLC	100.00%	4,151	4,151	25	
26	V	27	Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	542	542	26	
27	V	39	Ancillary	149,325	Therapy Works Rehabilitation Services, LLC	100.00%	133,316	(16,009)	27	
28	V	43	Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	19,205	19,205	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			\$ 149,325			\$ 171,581	\$ * 22,256	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center# 0046185Report Period Beginning: 01/01/07Ending: 12/31/07

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		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	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 119	\$ 119	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	934	934	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	78	78	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	202	202	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	278	278	20
21	V	21	Office and Clerical	806	Vent Lease, LLC.	100.00%		(806)	21
22	V	39	Ancillary	2,975	Vent Lease, LLC.	100.00%		(2,975)	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			\$ 3,781			\$ 1,611	\$ * (2,170)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 558	Xcel Supply, LLC	100.00%	\$ 513	\$ (45)	15
16	V	3 Housekeeping	9,577	Xcel Supply, LLC	100.00%	8,804	(772)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance	284	Xcel Supply, LLC	100.00%	262	(23)	18
19	V	10 Nursing	36,090	Xcel Supply, LLC	100.00%	33,180	(2,911)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	1,614	Xcel Supply, LLC	100.00%	1,484	(130)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	12,728	Xcel Supply, LLC	100.00%	11,701	(1,027)	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		\$ 60,852			\$ 55,944	\$ * (4,908)	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 70,014	\$ 70,014	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	70,014	CCS Employee Benefits Group	100.00%		(70,014)	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			\$ 70,014			\$ 70,014	\$ *	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: 01/01/07

Ending: 12/31/07

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								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	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: 01/01/07 Ending: 12/31/07

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	N/A	See Attached	0.34	0.74%		\$		1
2	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.38	1.09%	Alloc. Salary	332	22-7	2
3	Mark Steinberg	Relative	Administrative	N/A	See Attached	0.57	1.04%	Alloc. Salary	627	17-7	3
4	Adam Vales	Relative	Clerical	N/A	See Attached	0.43	1.08%	Alloc. Salary	603	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,562		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 16,714	\$ 70	1
2	02	Food	Patient Days	1,625,640	33	8,403	16,714	86	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	16,714	132	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	16,714	628	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	16,714	1,035	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	16,714	627	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	16,714	3,310	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	16,714	1,809	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	16,714	5,243	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	16,714	306	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	16,714	396	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	16,714	401	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	16,714	5,118	13
14	32	Interest	Patient Days	1,625,640	33	939,326	16,714	9,658	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	16,714	749	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	16,714	809	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	16,714	107	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	16,714	1,923	18
19	06	Maintenance	Direct Allocation			456,812	456,812	13,652	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	16,714	2,219	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	16,714	2,369	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	16,714	38,859	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	16,014	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	16,714	8,989	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 114,509	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 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	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 16,714	\$ 13	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	16,714	34	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	16,714	4	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	16,714	566	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	16,714	8	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	16,714	33	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	16,714	163	7	
8	26	Insurance	Patient Days	1,625,640	32	409	16,714	4	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	16,714	215	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	16,714	926	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	16,714	51	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	16,714	2	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	16,714	994	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	16,714	94	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	16,714	7,725	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	16,714	747	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	16,714	2,144	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	16,714	1,369	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	16,714	13,569	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	16,714	3,479	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	16,714	2,307	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22	
23	12	Social Service Salary	Direct Allocation			8,845	8,845		316	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			28	24
25	TOTALS					\$ 3,374,561	\$ 2,809,547	\$ 34,791	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Gross Billable Income	4,431,674	33	94,358	49,822	\$ 1,061	1	
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	49,822	7	2	
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	49,822	213	3	
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	49,822	87	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	49,822	23	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	49,822	132	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	49,822	455	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	49,822	100	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	49,822	192	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	49,822	150	10	
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	49,822	250	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	49,822	28	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	49,822	197	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	49,822	48	14	
15	01	Dietary	Direct Billable Income	341,879	33	112,243	3,702	1,215	15	
16	02	Food	Direct Billable Income	25	33	8			16	
17	03	Housekeeping	Direct Billable Income	29	33	10			17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856	9	3	18	
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20	
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	4,643	1,524	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	49,822	1,743	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	49,822	2,465	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	49,822	696	24	
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 10,589	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 Fax Number (847) 905-4040

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	17	Administration	Billable Income	4,671,432	16	\$ 9,000	\$ 162,129	\$ 312	1	
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	162,129	251	2	
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	162,129	209	3	
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	162,129	1,530	4	
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	162,129	543	5	
6	26	Insurance	Billable Income	4,671,432	16	15,816	162,129	549	6	
7	30	Depreciation	Billable Income	4,671,432	16	8,410	162,129	292	7	
8	32	Interest	Billable Income	4,671,432	16	78,317	162,129	2,718	8	
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	162,129	633	9	
10	39	Ancillary	Billable Income	4,671,432	16	211,187	162,129	7,330	10	
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	162,129	4,151	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	162,129	542	12	
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	162,129	133,316	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	162,129	19,205	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,943,774	\$ 3,960,830	\$ 171,581	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

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	06	Repairs	Direct Billing	892,186	27	\$ 35,557	\$ 2,975	\$ 119	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	2,975		2
3	30	Depreciation	Direct Billing	892,186	27	280,000	2,975	934	3
4	32	Interest	Direct Billing	892,186	27	23,404	2,975	78	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	16,714	202	5
6	32	Interest	Patient Days	1,625,640	33	27,081	16,714	278	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					\$ 385,762	\$	\$ 1,611	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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						\$ 513	1
2	3	Housekeeping						8,804	2
3	4	Laundry							3
4	6	Repairs & Maintenance						262	4
5	10	Nursing						33,180	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions							8
9	21	Office And Clerical							9
10	22	Employee Benefits						1,484	10
11	24	Seminars & Education							11
12	39	Ancillary						11,701	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							\$ 55,944	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, INC.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 70,014	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 70,014	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage			\$	\$ 1,234,056			\$ 64,069	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	LaSalle Bank		X	Line of Credit				166,503			19,010	6
7	Alloc. From Care Centers, Inc		X								9,658	7
8	See Supplemental Schedule										4,250	8
9	TOTAL Facility Related						\$	\$ 1,400,559			\$ 96,987	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,732)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(2,732)	14
15	TOTALS (line 9+line14)						\$	\$ 1,400,559			\$ 94,255	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.) SEE ACCOUNTANTS' COMPILATION REPORT

** 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: 01/01/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1							\$	\$			\$
2											
3											
4											
5											
6											
7	TOTAL Long-Term										
	Working Capital										
8	Alloc. From Care Centers Clinical		X				\$	\$			\$ 926
9	Alloc. From Care Centers Health System		X								250
10	Alloc. From Therapy Works		X								2,718
11	Alloc. From Vent Lease		X								356
12											
13											
14	TOTAL Working Capital										4,250
	B. Non-Facility Related*										
15							\$	\$			\$
16											
17											
18											
19											
20	TOTAL Non-Facility Related										

* 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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 17,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 18,487	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 687	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 18,542	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 19,229	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	13,644	8
	2003	15,124	9
	2004	16,158	10
	2005	16,945	11
	2006	17,659	12
<u>2007 Accrual = \$17659x1.05=\$18,542</u>			
<u>Allocation from Care Centers \$749</u>			
<u>Allocation from Care Centers Clinical \$51</u>			
<u>Allocation from Care Centers Health Systems \$28</u>			
		FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 08-10-220-006	Long Term Care Property	\$ 17,659.46	\$ 17,659.46
2. See Attached	Home Office Allocation	\$ 118,409.42	\$ 805.34
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>136,068.88</u>	\$ <u>18,464.80</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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, please call the Office of Health Finance at (217) 782-1630.

2000 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 Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>Facility</u>	<u>100,500</u>	<u>2003</u>	<u>\$ 139,765</u>	<u>1</u>
2	<u>2201 Main LLC</u>			<u>4,298</u>	<u>2</u>
3	TOTALS	100,500		\$ 144,063	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	9,788		20	489	489	2,062	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

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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		1,243,335	35,787		31,083	(4,704)	152,824	67
68		23,833	1,264		1,264		7,854	68
69			20,418			(20,418)		69
70		\$ 1,276,956	\$ 57,469		\$ 32,836	\$ (24,633)	\$ 162,740	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

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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		\$ 1,276,956	\$ 57,469		\$ 32,836	\$ (24,633)	\$ 162,740	1
2	Installation Of Chemical System	2004	2,185		20	109	109	437	2
3	Installation Of Chemical System Sales Tax	2004	138		20	7	7	26	3
4	Electric Repairs	2004	1,532		20	77	77	262	4
5	Interior Design Fees	2004	2,400		20	120	120	400	5
6	A/C Repair	2004	791		20	79	79	283	6
7	Replace Door Switches	2004	629		20	63	63	215	7
8	Wiring In New Call Station	2004	594		20	59	59	193	8
9	Carpeting	2005	42,808		20	2,855	2,855	7,136	9
10	Lovitt & Sons, Inc. - Concrete Sidewalk	2006	3,565		20	178	178	282	10
11	Painting (Transfer Expense From Home Office)	2007	17,949		20	11,966	11,966	11,966	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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
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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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
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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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center

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Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12G, Carried Forward	\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)	\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Report Period Beginning:

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Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
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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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12J, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

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Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,349,547	\$ 57,469		\$ 48,349	\$ (9,120)	\$ 183,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		2003	1972	\$ 1,243,335	\$ 35,787	40	\$ 31,083	\$ (4,704)	\$ 152,824	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											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

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

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)	\$	1,243,335	\$	35,787	\$	31,083	\$	(4,704)	\$	152,824	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		Allocated from Care Centers, Inc	2002	2002	\$ 4,578	\$ 117	39	\$ 117		\$ 621	4
5		Allocated from Care Centers-Hillside	1996	1996	7,763	199	39	199		2,198	5
6		Allocated from Care Centers Health Systems	2002	2002	266	7	39	7		36	6
7		Allocated from Care Centers Clinical	2002	2002	474	12	39	12		64	7
8											8
		Improvement Type**									
9		Allocated from Care Centers, Inc		2002	3,782	346	20	346		1,732	9
10		Allocated from Care Centers, Inc		2003	4,457	407	20	407		2,041	10
11		Allocated from Care Centers, Inc		2005	221	24	20	24		56	11
12		Allocated from Care Centers, Inc		2007	47	3	20	3		3	12
13											13
14		Allocated from Care Centers-Hillside		1996	131	-	20	-		131	14
15		Allocated from Care Centers-Hillside		1997	745	24	20	24		355	15
16											16
17		Allocated from Care Centers Health Systems		2002	220	20	20	20		100	17
18		Allocated from Care Centers Health Systems		2003	259	24	20	24		118	18
19		Allocated from Care Centers Health Systems		2005	13	1	20	1		3	19
20											20
21		Allocated from Care Centers Clinical		2002	392	36	20	36		179	21
22		Allocated from Care Centers Clinical		2003	462	42	20	42		211	22
23		Allocated from Care Centers Clinical		2005	23	2	20	2		6	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

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/07

Ending:

12/31/07

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)	\$	23,833	\$	1,264	\$	1,264	\$	7,854	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/07 Ending: 12/31/07

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	\$ 129,078	\$ 4,981	\$ 16,281	\$ 11,300	10	\$ 114,882	71
72	Current Year Purchases	5,536	50	432	382	10	432	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 134,614	\$ 5,031	\$ 16,713	\$ 11,682		\$ 115,314	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		Allocated from Care Centers, Inc		\$ 8,637	\$ 501	\$ 501	\$	5	\$ 7,095	76
77		Allocated from Care Centers Health Systems		142	5	5		5	5	77
78		Allocated from Care Centers Clinical		739	109	109		5	140	78
79										79
80	TOTALS			\$ 9,518	\$ 615	\$ 615	\$		\$ 7,240	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)		\$ 1,637,742	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 63,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 65,677	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 2,562	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 306,494	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Alloc from Care Centers				1,006			5
6								6
7	TOTAL				\$ 1,006			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,108 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 60,245	\$		\$ 60,245	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,475			13,475	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			73,735			73,735	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				73,667		73,667	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					1,575	25,580		27,155	13
14	TOTAL			\$		\$ 149,030	\$ 99,247		\$ 248,277	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center# 0046185Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$ 56,269	1
2	Cash-Patient Deposits	13,877	13,877	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	300,541	300,541	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,058	7,058	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	21,470	21,470	8
9	Other(specify): <u>See Attached Schedule</u>	39,152	39,152	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 382,598	\$ 438,367	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		139,765	13
14	Buildings, at Historical Cost		1,204,669	14
15	Leasehold Improvements, at Historical Cost	78,977	78,977	15
16	Equipment, at Historical Cost	23,702	30,768	16
17	Accumulated Depreciation (book methods)	(39,291)	(39,291)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		20,026	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,067)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	10,546	10,546	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 73,934	\$ 1,444,393	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 456,532	\$ 1,882,760	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 89,526	\$ 89,526	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,309	11,309	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,618	99,618	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,984	9,984	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,542	18,542	32
33	Accrued Interest Payable		7,270	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	14,796	36,266	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 243,775	\$ 272,515	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	166,503	166,503	39
40	Mortgage Payable		1,234,056	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 166,503	\$ 1,400,559	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 410,278	\$ 1,673,074	46
47	TOTAL EQUITY(page 18, line 24)	\$ 46,254	\$ 209,686	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 456,532	\$ 1,882,760	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 26,409	1
2	Restatements (describe):		2
3	<u>Late Entry</u>	(6,798)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 19,611	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	26,643	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 26,643	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 46,254	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center# 0046185Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,798,044	1
2	Discounts and Allowances for all Levels	(590,765)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,207,279	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	543,014	6
7	Oxygen	251	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 543,265	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,235	13
14	Non-Patient Meals	265	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	72,479	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,705	19
20	Radiology and X-Ray	2,540	20
21	Other Medical Services	84,567	21
22	Laundry	2,382	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 177,173	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,732	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,732	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,012	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,012	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,931,461	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	480,371	31
32	Health Care	1,196,586	32
33	General Administration	736,928	33
B. Capital Expense			
34	Ownership	214,350	34
C. Ancillary Expense			
35	Special Cost Centers	248,661	35
36	Provider Participation Fee	27,922	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,904,818	40
41	Income before Income Taxes (line 30 minus line 40)**	26,643	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 26,643	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,850	2,013	\$ 61,982	\$ 30.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,831	7,688	208,324	27.10	3
4	Licensed Practical Nurses	9,467	10,621	255,070	24.02	4
5	CNAs & Orderlies	27,897	30,487	417,520	13.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,204	4,587	68,207	14.87	8
9	Activity Director	1,800	2,154	28,475	13.22	9
10	Activity Assistants	1,251	1,300	10,315	7.93	10
11	Social Service Workers	3,806	4,183	65,424	15.64	11
12	Dietician	64	80	2,246	28.08	12
13	Food Service Supervisor	1,697	1,972	31,915	16.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,290	2,520	32,524	12.91	15
16	Dishwashers	5,427	5,876	58,306	9.92	16
17	Maintenance Workers	2,026	2,276	54,728	24.05	17
18	Housekeepers	6,466	6,647	57,895	8.71	18
19	Laundry	1,322	1,419	24,777	17.46	19
20	Administrator	2,025	2,131	75,398	35.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,703	3,049	51,857	17.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	81,126	89,003	\$ 1,504,963 *	\$ 16.91	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	115	\$ 5,069	01-03	35
36	Medical Director	Monthly	9,500	09-03	36
37	Medical Records Consultant	Monthly	514	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,070	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,188	11-03	44
45	Social Service Consultant	14	618	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	2	84	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	155	\$ 18,043		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 384	10-03	50
51	Licensed Practical Nurses	536	19,716	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	544	\$ 20,100		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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9													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. ILLTC -\$3728
- (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? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,469 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. \$ 27,922
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. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 265
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A 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. N/A
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT