

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>18,666</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>18,666</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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,591</u>	<u>4,595</u>	<u>1,729</u>	<u>16,915</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>10,591</u>	<u>4,595</u>	<u>1,729</u>	<u>16,915</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.62%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?

YES Date 02/01/2003 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 51 and days of care provided 1,622

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	129,667	16,826	4,631	151,124		151,124	913	152,037		1
2	Food Purchase		82,903		82,903		82,903	(1,463)	81,440		2
3	Housekeeping	72,343	13,943	277	86,563		86,563	(739)	85,824		3
4	Laundry	27,792	13,022		40,814		40,814	(146)	40,668		4
5	Heat and Other Utilities			60,529	60,529		60,529	945	61,474		5
6	Maintenance	23,679		44,711	68,390		68,390	4,091	72,481		6
7	Other (specify):*							854	854		7
8	TOTAL General Services	253,481	126,694	110,148	490,323		490,323	4,456	494,779		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	986,692	47,971	24,372	1,059,035		1,059,035	6,245	1,065,280		10
10a	Therapy	86,836			86,836		86,836	767	87,603		10a
11	Activities	57,884	2,082		59,966		59,966		59,966		11
12	Social Services	63,997		768	64,765		64,765	4,456	69,221		12
13	CNA Training										13
14	Program Transportation			80	80		80		80		14
15	Other (specify):*							2,593	2,593		15
16	TOTAL Health Care and Programs	1,195,409	50,053	34,820	1,280,282		1,280,282	14,061	1,294,343		16
	C. General Administration										
17	Administrative	84,456			84,456		84,456	20,103	104,559		17
18	Directors Fees										18
19	Professional Services			179,216	179,216		179,216	(121,247)	57,969		19
20	Dues, Fees, Subscriptions & Promotions			30,313	30,313		30,313	(7,939)	22,374		20
21	Clerical & General Office Expenses	59,402	10,750	148,098	218,250		218,250	(30,515)	187,735		21
22	Employee Benefits & Payroll Taxes			244,587	244,587		244,587	(6,818)	237,769		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,442	5,442		5,442	816	6,258		24
25	Other Admin. Staff Transportation			3,143	3,143		3,143	463	3,606		25
26	Insurance-Prop.Liab.Malpractice			50,438	50,438		50,438	729	51,167		26
27	Other (specify):*							12,861	12,861		27
28	TOTAL General Administration	143,858	10,750	661,237	815,845		815,845	(131,547)	684,298		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,592,748	187,497	806,205	2,586,450		2,586,450	(113,030)	2,473,420		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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			14,379	14,379	14,379	32,272	46,651			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			17,617	17,617	17,617	61,922	79,539			32
33	Real Estate Taxes			18,161	18,161	18,161	1,386	19,547			33
34	Rent-Facility & Grounds			156,000	156,000	156,000	(154,820)	1,180			34
35	Rent-Equipment & Vehicles			2,891	2,891	2,891	811	3,702			35
36	Other (specify):*										36
37	TOTAL Ownership			209,048	209,048	209,048	(58,429)	150,619			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		105,385	124,520	229,905	229,905	(33,931)	195,974			39
40	Barber and Beauty Shops			167	167	167	(167)				40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			28,000	28,000	28,000		28,000			42
43	Other (specify):*						12,468	12,468			43
44	TOTAL Special Cost Centers		105,385	152,687	258,072	258,072	(21,630)	236,442			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,592,748	292,882	1,167,940	3,053,570	3,053,570	(193,089)	2,860,481			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: 01/01/08

Ending: 12/31/08

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	(818)	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	(10,644)	30		9
10	Interest and Other Investment Income	(39)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(225)	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	(653)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,413)	21		24
25	Fund Raising, Advertising and Promotional	(6,657)	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	(42,297)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (108,747)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(84,342)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (84,342)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (193,089)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Snow Valley Nursing & Rehab Center

ID# 0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (564)	02	1
2	Barber & Beauty	(167)	40	2
3	Misc. Income	(574)	21	3
4	Jury Duty	(57)	10	4
5	Patient Clothing	(70)	10	5
6	Collection Expense	(117)	21	6
7	Non-Allowable Expenses	(30,000)	21	7
8	Non-Allowable Legal	(217)	19	8
9	Public Relations	(648)	20	9
10	COPE Dues	(1,774)	20	10
11				11
12	Building Co.-Bank Charges	(42)	21	12
13	Building Co.- Amortizatoin	(4,005)	36	13
14	Building Co.-Filling Fees	(250)	21	14
15				15
16				16
17	Prior Year Expenses	(3,345)	21	17
18	Annual Report	(250)	20	18
19	Non-allowable Marketing Expenses	(218)	19	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(42,297)		49

Snow Valley Nursing & Rehab Center

ID# 0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/08

Ending:

12/31/08

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			143		1,048	(211)	(67)					913	1
2	Food Purchase	(1,607)		144									(1,463)	2
3	Housekeeping			141		16		(896)					(739)	3
4	Laundry							(146)					(146)	4
5	Heat and Other Utilities			859		36	50						945	5
6	Maintenance			1,085	2,170	4	9			823			4,091	6
7	Other (specify):*				719	135							854	7
8	TOTAL General Services	(1,607)		2,372	2,889	1,239	(152)	(1,109)		823			4,456	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(127)				8,976		(2,604)					6,245	10
10a	Therapy					767							767	10a
11	Activities													11
12	Social Services					4,456							4,456	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					2,593							2,593	15
16	TOTAL Health Care and Programs	(127)				16,792		(2,604)					14,061	16
	C. General Administration													
17	Administrative			683	2,547	13,011	720				3,142		20,103	17
18	Directors Fees													18
19	Professional Services	(435)		(94,551)		(27,749)	28				1,460		(121,247)	19
20	Fees, Subscriptions & Promotions	(9,982)		1,891		3	24				125		(7,939)	20
21	Clerical & General Office Expenses	(81,741)	292	8,252	39,550	4,420	853			(3,265)	1,124		(30,515)	21
22	Employee Benefits & Payroll Taxes				(6,704)			(114)					(6,818)	22
23	Inservice Training & Education													23
24	Travel and Seminar			482		55					279		816	24
25	Other Admin. Staff Transportation			411			47			5			463	25
26	Insurance-Prop.Liab.Malpractice			298		5	58			17	351		729	26
27	Other (specify):*				10,046	2,244	199				372		12,861	27
28	TOTAL General Administration	(92,158)	292	(82,534)	45,439	(8,011)	1,929	(114)		(3,243)	6,853		(131,547)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(93,891)	292	(80,162)	48,328	10,020	1,777	(3,827)		(2,420)	6,853		(113,030)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	(10,644)	33,433	3,934		263	53			5,026	207		32,272	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(39)	46,564	10,686		1,979	164			993	1,575		61,922	32
33	Real Estate Taxes			1,328		58							1,386	33
34	Rent-Facility & Grounds		(156,000)	1,008			172						(154,820)	34
35	Rent-Equipment & Vehicles			337			17				457		811	35
36	Other (specify):*	(4,005)	4,005											36
37	TOTAL Ownership	(14,688)	(71,998)	17,293		2,300	406			6,019	2,239		(58,429)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,239)	(3,017)		(6,930)	(20,745)		(33,931)	39
40	Barber and Beauty Shops	(167)											(167)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*										12,468		12,468	43
44	TOTAL Special Cost Centers	(167)					(3,239)	(3,017)		(6,930)	(8,277)		(21,630)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(108,747)	(71,706)	(62,869)	48,328	12,320	(1,056)	(6,844)		(3,331)	815		(193,089)	45

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 Healthcare Properties, LLC		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 Rent	\$ 156,000	Snow Valley Healthcare Properties, LLC	100.00%	\$	\$ (156,000)	1
2	V	33 Real Estate Taxes	18,161	Snow Valley Healthcare Properties, LLC	100.00%	18,161		2
3	V	21 Bank Charges		Snow Valley Healthcare Properties, LLC	100.00%	42	42	3
4	V	21 Filing Fees		Snow Valley Healthcare Properties, LLC	100.00%	250	250	4
5	V	32 Interest Expenses		Snow Valley Healthcare Properties, LLC	100.00%	46,564	46,564	5
6	V	30 Depreciation		Snow Valley Healthcare Properties, LLC	100.00%	33,433	33,433	6
7	V	36 Amortization		Snow Valley Healthcare Properties, LLC	100.00%	4,005	4,005	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 174,161			\$ 102,455	\$ * (71,706)	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# 0046185Report Period Beginning: 01/01/08Ending: 12/31/08

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. / Extended Care Consulting, LLC	100.00%	\$ 143	\$ 143	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	144	144	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	141	141	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	859	859	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,085	1,085	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	683	683	20	
21	V	19	Professional Fees	99,637	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,086	(94,551)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,891	1,891	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,252	8,252	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	482	482	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	411	411	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	298	298	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,934	3,934	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	10,686	10,686	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,328	1,328	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,008	1,008	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	337	337	31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 99,637			\$ 36,768	\$ * (62,869)	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	06 Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,094	\$ 2,094	15
16	V	06 Maintenance (Direct)	349	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	425	76	16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	657	657	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	62	62	18
19	V	17 Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,547	2,547	19
20	V	21 Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	39,626	39,626	20
21	V	21 Office and Clerical (Direct)	24,006	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	23,930	(76)	21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,295	6,295	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,751	3,751	23
24	V	22 Emp. Ben. - Gen. Admin. (Direct)	6,704				(6,704)	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		\$ 31,059			\$ 79,387	\$ * 48,328	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: 01/01/08 Ending: 12/31/08

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	03	Housekeeping	\$	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	\$ 16	\$ 16	15
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	36	36	16
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	4	4	17
18	V	19	Professional Fees	28,153	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	404	(27,749)	18
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3	3	19
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	68	68	20
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	55	55	21
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	5	5	22
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	263	263	23
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,979	1,979	24
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	58	58	25
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,048	1,048	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	135	135	27
28	V	10	Nursing Salary	8,395	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	17,371	8,976	28
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	767	767	29
30	V	12	Social Service Salary	768	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	5,224	4,456	30
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	2,593	2,593	31
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	13,011	13,011	32
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	4,352	4,352	33
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	2,244	2,244	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 37,316			\$ 49,636	\$ * 12,320	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: 01/01/08Ending: 12/31/08

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 Health Systems, Inc.	100.00%	\$ 446	\$ 446	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	50	50	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	9	9	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	28	28	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	24	24	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	109	109	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	47	47	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	58	58	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	53	53	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	164	164	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	172	172	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	17	17	28	
29	V	01	Dietary	1,041	Care Centers Health Systems, Inc.	100.00%	384	(657)	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		Care Centers Health Systems, Inc.	100.00%			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	5,131	Care Centers Health Systems, Inc.	100.00%	1,892	(3,239)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	720	720	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	744	744	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	199	199	38	
39	Total			\$ 6,172			\$ 5,116	\$ * (1,056)	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	\$ 752	Xcel Supply, LLC	100.00%	\$ 686	\$ (67)	15
16	V	3 Housekeeping	10,116	Xcel Supply, LLC	100.00%	9,220	(896)	16
17	V	4 Laundry	1,647	Xcel Supply, LLC	100.00%	1,501	(146)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	29,395	Xcel Supply, LLC	100.00%	26,791	(2,604)	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	1,291	Xcel Supply, LLC	100.00%	1,177	(114)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	34,059	Xcel Supply, LLC	100.00%	31,042	(3,017)	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		\$ 77,261			\$ 70,417	\$ * (6,844)	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%	\$ 69,773	\$ 69,773	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	69,773	CCS Employee Benefits Group	100.00%		(69,773)	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			\$ 69,773			\$ 69,773	\$ *	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	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 823	\$ 823	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	92	92	16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%	5	5	17
18	V	26	Insurance		Vent Lease, LLC.	100.00%	17	17	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	2,736	2,736	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	461	461	20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	2,290	2,290	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	532	532	22
23	V	21	Office and Clerical	3,357	Vent Lease, LLC.	100.00%		(3,357)	23
24	V	39	Ancillary	6,930	Vent Lease, LLC.	100.00%		(6,930)	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			\$ 10,287			\$ 6,956	\$ * (3,331)	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: 01/01/08Ending: 12/31/08

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%	\$ 333	\$ 333	15	
16	V	19	Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	1,460	1,460	16	
17	V	20	Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	125	125	17	
18	V	21	Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	1,124	1,124	18	
19	V	24	Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	279	279	19	
20	V	26	Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	351	351	20	
21	V	30	Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	207	207	21	
22	V	32	Interest		Therapy Works Rehabilitation Services, LLC	100.00%	1,575	1,575	22	
23	V	35	Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	457	457	23	
24	V	39	Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	10	10	24	
25	V	39	Ancillary (Direct)		Therapy Works Rehabilitation Services, LLC	100.00%			25	
26	V	17	Administrative Salaries		Therapy Works Rehabilitation Services, LLC	100.00%	2,809	2,809	26	
27	V	27	Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	372	372	27	
28	V	39	Ancillary Salaries	115,024	Therapy Works Rehabilitation Services, LLC	100.00%	94,269	(20,755)	28	
29	V	43	Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	12,468	12,468	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			\$ 115,024			\$ 115,839	\$ *	815	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: 01/01/08 Ending: 12/31/08

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	Mark Steinberg	Relative	Administrative	N/A	See Attached	0.57	1.04%	Alloc. Salary	1,581	17-7	2
3											3
4	Adam Vales	Relative	Clerical	N/A	See Attached	0.53	1.33%	Alloc. Salary	960	22-7	4
5	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.22	1.32%	Alloc. Salary	195	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,736		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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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/Extended Care Consulting LLC
 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	1,635,146	31	\$ 13,778	\$ 16,915	\$ 143	1
2	02	Food	Patient Days	1,635,146	31	13,971	16,915	144	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	16,915	141	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	16,915	859	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	16,915	1,085	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	16,915	683	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	16,915	5,086	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	16,915	1,891	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	16,915	8,252	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	16,915	482	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	16,915	411	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	16,915	298	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	16,915	3,934	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	16,915	10,686	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	16,915	1,328	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	16,915	1,008	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	16,915	337	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 36,768	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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/Extended Care Consulting LLC
 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	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	16,915	2,094	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		425	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		16,915	657	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			62	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	16,915	2,547	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	16,915	39,626	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		23,930	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		16,915	6,295	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			3,751	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					\$ 6,211,280	\$ 5,395,924		\$ 79,387	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Center Clinical/Extended Care Clinical
 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	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 16,915	\$ 16	1	
2	05	Utilities	Patient Days	1,635,146	31	3,449	16,915	36	2	
3	06	Maintenance	Patient Days	1,635,146	31	431	16,915	4	3	
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	16,915	404	4	
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	16,915	3	5	
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	16,915	68	6	
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	16,915	55	7	
8	26	Insurance	Patient Days	1,635,146	31	465	16,915	5	8	
9	30	Depreciation	Patient Days	1,635,146	31	25,565	16,915	263	9	
10	32	Interest	Patient Days	1,635,146	31	191,164	16,915	1,979	10	
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	16,915	58	11	
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	16,915	1,048	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	16,915	135	13	
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	16,915	8,976	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	16,915	767	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	16,915	4,456	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	16,915	1,836	17	
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	16,915	13,011	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	16,915	4,352	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	16,915	2,244	20	
21	10	Nursing Salary	Direct Allocation			401,447	401,447		8,395	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016		768	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816			757	23
24										24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 49,636		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

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	31	3,867,056	111,096	15,507	446	1	
2	03	Housekeeping	Gross Billable Income	31	3,867,056		15,507		2	
3	05	Heat and Other Utilities	Gross Billable Income	31	3,867,056	12,529	15,507	50	3	
4	06	Maintenance	Gross Billable Income	31	3,867,056	2,136	15,507	9	4	
5	19	Professional Fees	Gross Billable Income	31	3,867,056	6,873	15,507	28	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	3,867,056	6,095	15,507	24	6	
7	21	Clerical and General Office	Gross Billable Income	31	3,867,056	27,280	15,507	109	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	3,867,056	11,773	15,507	47	8	
9	26	Insurance	Gross Billable Income	31	3,867,056	14,568	15,507	58	9	
10	30	Depreciation	Gross Billable Income	31	3,867,056	13,298	15,507	53	10	
11	32	Interest	Gross Billable Income	31	3,867,056	40,850	15,507	164	11	
12	33	Real Estate Taxes	Gross Billable Income	31	3,867,056		15,507		12	
13	34	Rent - Building	Gross Billable Income	31	3,867,056	43,000	15,507	172	13	
14	35	Rent - Equipment	Gross Billable Income	31	3,867,056	4,135	15,507	17	14	
15	01	Dietary	Direct Billable Income	31	279,198	102,965	1,041	384	15	
16	02	Food	Direct Billable Income	31	4,372	1,612			16	
17	03	Housekeeping	Direct Billable Income	31					17	
18	10	Nursing	Direct Billable Income	31					18	
19	21	Clerical and General Office	Direct Billable Income	31					19	
20	25	Other Admin. Staff Transport.	Direct Billable Income	31					20	
21	39	Ancillary	Direct Billable Income	31	3,583,486	1,321,550	5,131	1,892	21	
22	17	Administrative	Gross Billable Income	31	3,867,056	179,474	179,474	15,507	720	22
23	21	Clerical and General Office	Gross Billable Income	31	3,867,056	185,549	185,549	15,507	744	23
24	27	Employee Benefits	Gross Billable Income	31	3,867,056	49,573	15,507	199	24	
25	TOTALS					\$ 2,134,357	\$ 365,023	\$ 5,116	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	Direct Allocation		\$	\$		686	1
2	3	Housekeeping	Direct Allocation					9,220	2
3	4	Laundry	Direct Allocation					1,501	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					26,791	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					1,177	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					31,042	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				\$	\$		70,417	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Main Street
 City / State / Zip Code Evanston, Illinois 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		\$	\$		\$ 69,773	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				\$	\$		\$ 69,773	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	669,310	26	\$ 79,460	\$ 6,930	\$ 823	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933	6,930	92	2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473	6,930	5	3
4	26	Insurance	Direct Billing	669,310	26	1,630	6,930	17	4
5	30	Depreciation	Direct Billing	669,310	26	264,263	6,930	2,736	5
6	32	Interest	Direct Billing	669,310	26	44,568	6,930	461	6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	16,915	2,290	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	16,915	532	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					\$ 672,138	\$	\$ 6,956	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 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

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	17	Administration	Billable Income	(4,665,397)	14	\$ 13,500	\$ (115,024)	\$ 333	1	
2	19	Professional Fees	Billable Income	(4,665,397)	14	59,199	(115,024)	1,460	2	
3	20	Dues and Subscriptions	Billable Income	(4,665,397)	14	5,081	(115,024)	125	3	
4	21	Office & Clerical	Billable Income	(4,665,397)	14	45,575	(115,024)	1,124	4	
5	24	Travel and Seminar	Billable Income	(4,665,397)	14	11,318	(115,024)	279	5	
6	26	Insurance	Billable Income	(4,665,397)	14	14,252	(115,024)	351	6	
7	30	Depreciation	Billable Income	(4,665,397)	14	8,410	(115,024)	207	7	
8	32	Interest	Billable Income	(4,665,397)	14	63,875	(115,024)	1,575	8	
9	35	Rent - Equipment	Billable Income	(4,665,397)	14	18,528	(115,024)	457	9	
10	39	Ancillary	Billable Income	(4,665,397)	14	389	(115,024)	10	10	
11	39	Ancillary (Direct)	Direct			143,969			11	
12	17	Administrative Salaries	Billable Income	(4,665,397)	14	113,937	113,937	(115,024)	2,809	12
13	27	Emp. Ben. - Gen. Admin.	Billable Income	(4,665,397)	14	15,069	(115,024)	372	13	
14	39	Ancillary Salaries	Billable Income	(4,665,397)	14	3,823,568	3,823,568	(115,024)	94,269	14
15	43	Emp. Ben. - Other	Billable Income	(4,665,397)	14	505,700	(115,024)	12,468	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,842,370	\$ 3,937,504	\$ 115,839	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/08

Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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	Bank of America		X	Mortgage			\$	\$ 1,127,532			\$ 46,564	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
Working Capital												
6	LaSalle Bank		X	Line of Credit				512,759			17,617	6
7	Alloc. From Care Centers, Inc.		X									7
8	See Supplemental Schedule										2,732	8
9	TOTAL Facility Related						\$	\$ 1,640,291			\$ 66,913	9
B. Non-Facility Related*												
10	Interest Income		X								(39)	10
11	Allocated from CCI/ECC		X								10,686	11
12	Allocated from CC/EC Clinical		X								1,979	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			\$ 12,626	14
15	TOTALS (line 9+line14)						\$	\$ 1,640,291			\$ 79,539	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: 01/01/08 Ending: 12/31/08

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8	Allocated from CC Health Sys.		X							164										
9	Allocated from Vent Lease		X							993										
10	Allocated from Therapy Works		X							1,575										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									2,732										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

* 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 2007 report.		\$ 18,542	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.)		\$ 19,290	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ 748	3																				
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 18,799	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.		\$ 19,547	7																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2003</td> <td>15,124</td> <td>8</td> </tr> <tr> <td></td> <td>2004</td> <td>16,158</td> <td>9</td> </tr> <tr> <td></td> <td>2005</td> <td>16,945</td> <td>10</td> </tr> <tr> <td></td> <td>2006</td> <td>17,659</td> <td>11</td> </tr> <tr> <td></td> <td>2007</td> <td>17,904</td> <td>12</td> </tr> </table> <p>2008 Accrual = \$17904 x 1.05 = \$18,799 Allocated from: CCI / ECC \$1,528, CC / EC Clinical \$58</p>				Real Estate Tax Bill for Calendar Year:	2003	15,124	8		2004	16,158	9		2005	16,945	10		2006	17,659	11		2007	17,904	12
Real Estate Tax Bill for Calendar Year:	2003	15,124	8																				
	2004	16,158	9																				
	2005	16,945	10																				
	2006	17,659	11																				
	2007	17,904	12																				
		FOR BHF USE ONLY																					
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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. <u>08-10-220-006</u>	<u>Long Term Care Property</u>	\$ <u>17,904.23</u>	\$ <u>17,904.23</u>
2. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>565.46</u>
3. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>43,667.89</u>	\$ <u>301.15</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>183,694.87</u>	\$ <u>18,770.84</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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.

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185 Report Period Beginning:

01/01/08 Ending:

12/31/08

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>	1
2	<u>Allocated From CCI/ECC</u>			<u>4,262</u>	2
3	TOTALS	100,500		\$ 144,027	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	2,552	9
10	Various		2004		8,269		20	514	514	2,330	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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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											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

Report Period Beginning:

01/01/08

Ending:

12/31/08

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
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61								61
62								62
63								63
64								64
65								65
66								66
67		1,243,335	30,889		31,083	194	183,907	67
68		23,788	1,255		1,255		8,201	68
69			18,091			(18,091)		69
70		\$ 1,285,180	\$ 50,235		\$ 33,341	\$ (16,894)	\$ 196,990	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:

01/01/08 Ending:

12/31/08

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 12A, Carried Forward		\$ 1,285,180	\$ 50,235		\$ 33,341	\$ (16,894)	\$ 196,990	1
2	Carpeting	2005	42,808		20	2,855	2,855	9,991	2
3	Lovitt & Sons, Inc. - Concrete Sidewalk	2006	3,565		20	178	178	460	3
4	Painting (Transfer Expense From Home Office)	2007	17,949		20	5,983	5,983	17,949	4
5	Architectural Additions	2008	3,078		20	77	77	77	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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 12G, Carried Forward		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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 12J, Carried Forward		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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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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)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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)		\$ 1,352,580	\$ 50,235		\$ 42,434	\$ (7,801)	\$ 225,467	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:

01/01/08

Ending:

12/31/08

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	\$ 30,889	40	\$ 31,083	\$ 194	\$ 183,907	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:

01/01/08

Ending:

12/31/08

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	\$	30,889	\$	31,083	\$	194	\$	183,907	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:

01/01/08

Ending:

12/31/08

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 EC/CC Clinical, Inc.	2002	2002	\$ 517	\$ 13	39	\$ 13		\$ 83	4
5		Allocated from CCI/ECC - CCI Building	2006	1996	7,865	202	39	202		2,428	5
6		Allocated from CCI/Extended Care Consulting, LLC	2002	2002	4,745	122	39	122		766	6
7											7
8											8
		Improvement Type**									
9		Allocated from CCI/Extended Care Consulting, LLC		2002	3,920	358	20	358		1,795	9
10		Allocated from CCI/Extended Care Consulting, LLC		2003	4,619	422	20	422		2,115	10
11		Allocated from CCI/Extended Care Consulting, LLC		2005	230	24	20	24		58	11
12		Allocated from CCI/Extended Care Consulting, LLC		2007	48	2	20	2		6	12
13											13
14		Allocated from CCI/ECC- CCI Building		1996	133	-	20	-		133	14
15		Allocated from CCI/ECC- CCI Building		1997	755	24	20	24		384	15
16											16
17		Allocated from CC/EC Clinical, Inc.		2002	427	39	20	39		196	17
18		Allocated from CC/EC Clinical, Inc.		2003	504	46	20	46		231	18
19		Allocated from CC/EC Clinical, Inc.		2005	25	3	20	3		6	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:

01/01/08

Ending:

12/31/08

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)	\$	23,788	\$	1,255	\$	1,255	\$	8,201	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: 01/01/08 Ending: 12/31/08

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	\$ 62,601	\$ 10,046	\$ 7,203	\$ (2,843)	10	\$ 50,467	71
72	Current Year Purchases	104	8	8		10	8	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 62,705	\$ 10,054	\$ 7,211	\$ (2,843)		\$ 50,475	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 CCC/EC Clinical	2008	\$ 741	\$ 148	\$ 148	\$	5	\$ 288	76
77		Allocated from CCI/ECC	2008	9,012	560	560		5	7,748	77
78		Allocated from CC Health Sys	2008	51	10	10		5	12	78
79										79
80	TOTALS			\$ 9,804	\$ 718	\$ 718	\$		\$ 8,048	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)	\$ 1,569,116	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,007	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,363	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,644)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 283,990	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	Allocated from CCI/ECC				1,008			5
6	Allocated from CC Health Sys.				172			6
7	TOTAL				\$ 1,180			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 3,702 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	\$		\$ 37,073	\$		\$ 37,073	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,656			13,656	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			67,510			67,510	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				61,958		61,958	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					6,281	43,427		49,708	13
14	TOTAL			\$		\$ 124,520	\$ 105,385		\$ 229,905	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: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ 27,212	1
2	Cash-Patient Deposits	14,098	14,098	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	582,254	582,254	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,372	7,372	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>	18,627	18,627	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 644,321	\$ 671,033	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	82,054	82,054	15
16	Equipment, at Historical Cost	23,702	30,768	16
17	Accumulated Depreciation (book methods)	(53,670)	(94,245)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		20,026	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,006)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	24,260	24,260	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 76,346	\$ 1,402,291	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 720,667	\$ 2,073,324	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 153,444	\$ 153,445	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,981	11,981	28
29	Short-Term Notes Payable	512,759	512,759	29
30	Accrued Salaries Payable	38,964	38,964	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,874	17,874	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,799	18,799	32
33	Accrued Interest Payable		6,361	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	55,464	76,934	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 809,285	\$ 837,117	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,127,532	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)	\$	\$ 1,127,532	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 809,285	\$ 1,964,649	46
47	TOTAL EQUITY(page 18, line 24)	\$ (88,618)	\$ 108,675	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 720,667	\$ 2,073,324	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 46,254	1
2	Restatements (describe):		2
3	Pension Expense	(333)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 45,921	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(106,983)	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	(27,556)	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)	\$ (134,539)	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)	\$ (88,618)	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: 01/01/08Ending: 12/31/08**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	\$ 2,859,612	1
2	Discounts and Allowances for all Levels	(451,144)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,408,468	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	373,470	6
7	Oxygen	142	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 373,612	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	1,923	13
14	Non-Patient Meals	818	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	64,409	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,328	19
20	Radiology and X-Ray	1,860	20
21	Other Medical Services	86,390	21
22	Laundry	545	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 163,273	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	39	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,195	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,195	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,946,587	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	490,323	31
32	Health Care	1,280,282	32
33	General Administration	815,845	33
B. Capital Expense			
34	Ownership	209,048	34
C. Ancillary Expense			
35	Special Cost Centers	230,072	35
36	Provider Participation Fee	28,000	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,053,570	40
41	Income before Income Taxes (line 30 minus line 40)**	(106,983)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (106,983)	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: 01/01/08

Ending:

12/31/08

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	1,474	1,682	\$ 64,567	\$ 38.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,251	7,819	231,940	29.66	3
4	Licensed Practical Nurses	10,248	11,255	271,219	24.10	4
5	CNAs & Orderlies	28,073	30,145	418,966	13.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,953	5,461	86,836	15.90	8
9	Activity Director	1,807	2,043	30,263	14.81	9
10	Activity Assistants	2,761	2,992	27,621	9.23	10
11	Social Service Workers	3,704	4,066	63,997	15.74	11
12	Dietician	216	232	3,944	17.00	12
13	Food Service Supervisor	1,286	1,430	25,570	17.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,467	3,829	48,683	12.71	15
16	Dishwashers	4,794	5,077	51,470	10.14	16
17	Maintenance Workers	903	1,039	23,679	22.79	17
18	Housekeepers	7,455	7,951	72,343	9.10	18
19	Laundry	3,111	3,141	27,792	8.85	19
20	Administrator	1,976	2,155	84,456	39.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,476	3,862	59,402	15.38	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)	86,955	94,179	\$ 1,592,748 *	\$ 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	102	\$ 4,631	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	536	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached</u>		9,163		48
49	TOTAL (lines 35 - 48)	102	\$ 23,930		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses	418	15,441	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	418	\$ 15,441		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

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. ILCLTC - \$2983.50
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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. \$ 21,021 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. \$ 28,000
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. \$ 818
- (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