

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>51</u>	Skilled (SNF)	<u>51</u>	<u>18,615</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>51</u>	TOTALS	<u>51</u>	<u>18,615</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>11,234</u>	<u>2,752</u>	<u>1,231</u>	<u>15,217</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>11,234</u>	<u>2,752</u>	<u>1,231</u>	<u>15,217</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.75%

D. How many bed-hold days during this year were paid by the Department? 10 (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 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2003 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 1,122

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	139,603	18,724	4,073	162,400		162,400	488	162,888		1
2	Food Purchase		70,808		70,808		70,808	(1,612)	69,196		2
3	Housekeeping	83,873	17,803		101,676		101,676	(1,208)	100,468		3
4	Laundry	37,210	11,124	74	48,408		48,408	(503)	47,905		4
5	Heat and Other Utilities			54,533	54,533		54,533	715	55,248		5
6	Maintenance	24,985		44,156	69,141		69,141	4,318	73,459		6
7	Other (specify):*							678	678		7
8	TOTAL General Services	285,671	118,459	102,836	506,966		506,966	2,875	509,841		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	970,872	63,581	27,655	1,062,108		1,062,108	(4,764)	1,057,344		10
10a	Therapy	113,729			113,729		113,729	509	114,238		10a
11	Activities	75,857	5,402		81,259		81,259		81,259		11
12	Social Services	49,273		1,683	50,956		50,956	2,776	53,732		12
13	CNA Training										13
14	Program Transportation			290	290		290		290		14
15	Other (specify):*							2,235	2,235		15
16	TOTAL Health Care and Programs	1,209,731	68,983	39,228	1,317,942		1,317,942	756	1,318,698		16
	C. General Administration										
17	Administrative	96,317			96,317		96,317	15,977	112,294		17
18	Directors Fees										18
19	Professional Services			172,163	172,163		172,163	(128,817)	43,346		19
20	Dues, Fees, Subscriptions & Promotions			24,565	24,565		24,565	(5,491)	19,074		20
21	Clerical & General Office Expenses	51,515	11,997	182,603	246,115		246,115	(81,518)	164,597		21
22	Employee Benefits & Payroll Taxes			241,384	241,384		241,384	(5,857)	235,527		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,792	4,792		4,792	319	5,111		24
25	Other Admin. Staff Transportation			4,366	4,366		4,366	109	4,475		25
26	Insurance-Prop.Liab.Malpractice			54,497	54,497		54,497	391	54,888		26
27	Other (specify):*							12,456	12,456		27
28	TOTAL General Administration	147,832	11,997	684,370	844,199		844,199	(192,431)	651,768		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,643,234	199,439	826,434	2,669,107		2,669,107	(188,800)	2,480,307		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			10,710	10,710		10,710	30,666	41,376			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,050	19,050		19,050	148,291	167,341			32
33	Real Estate Taxes			19,663	19,663		19,663	683	20,346			33
34	Rent-Facility & Grounds			156,000	156,000		156,000	(154,584)	1,416			34
35	Rent-Equipment & Vehicles			1,016	1,016		1,016	759	1,775			35
36	Other (specify):*											36
37	TOTAL Ownership			206,439	206,439		206,439	25,815	232,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,250	139,375	247,625		247,625	16,936	264,561			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,923	27,923		27,923		27,923			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		108,250	167,298	275,548		275,548	16,936	292,484			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,643,234	307,689	1,200,171	3,151,094		3,151,094	(146,049)	3,005,045			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

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	(1,044)	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	(8,981)	30		9
10	Interest and Other Investment Income	(5,005)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(125)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(544)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,583)	21		24
25	Fund Raising, Advertising and Promotional	(4,347)	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	(91,337)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (164,966)		\$	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)	18,917		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,917		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (146,049)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Snow Valley Nursing & Rehab Center

ID# 0046185

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (610)	02	1
2	Gait Belt Revenue	(80)	10	2
3	Theft Loss	(65)	21	3
4	Account Collection Expenses	(133)	21	4
5	Prior Period Nursing Expense	(9,931)	10	5
6	Non-Allowable Office Expense	(73,343)	21	6
7	Annual Report	(250)	20	7
8	COPE Dues	(1,537)	20	8
9	Building Company Bank Charges	(250)	21	9
10	Building Company Repalcement Taxes	(510)	21	10
11	Building Company Amortization	(4,005)	31	11
12	Non-Allowable Legal	(584)	19	12
13	Non-Allowable Travel	(39)	25	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(91,337)		49

Snow Valley Nursing & Rehab Center

ID# 0046185

Report Period Beginning: 01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			75		1,299	(56)				(830)		488	1
2	Food Purchase	(1,779)		167									(1,612)	2
3	Housekeeping			155		17	(1,380)						(1,208)	3
4	Laundry						(503)						(503)	4
5	Heat and Other Utilities			637		41					37		715	5
6	Maintenance			989	2,424	5			872		28		4,318	6
7	Other (specify):*				490	188							678	7
8	TOTAL General Services	(1,779)		2,023	2,914	1,550	(1,940)		872		(765)		2,875	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(10,555)				9,315	(3,524)						(4,764)	10
10a	Therapy					509							509	10a
11	Activities													11
12	Social Services					2,776							2,776	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					2,235							2,235	15
16	TOTAL Health Care and Programs	(10,555)				14,835	(3,524)						756	16
	C. General Administration													
17	Administrative			730	2,646	11,538					1,063		15,977	17
18	Directors Fees													18
19	Professional Services	(584)		(100,523)		(27,798)			48		40		(128,817)	19
20	Fees, Subscriptions & Promotions	(6,134)		625		2					16		(5,491)	20
21	Clerical & General Office Expenses	(127,884)	760	5,112	40,629	2,588			(4,009)		1,286		(81,518)	21
22	Employee Benefits & Payroll Taxes				(4,565)	(1,191)	(101)						(5,857)	22
23	Inservice Training & Education													23
24	Travel and Seminar			20		299							319	24
25	Other Admin. Staff Transportation	(39)		114					4		30		109	25
26	Insurance-Prop.Liab.Malpractice			251		15			49		76		391	26
27	Other (specify):*				9,987	2,005					464		12,456	27
28	TOTAL General Administration	(134,641)	760	(93,671)	48,697	(12,542)	(101)		(3,908)		2,975		(192,431)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(146,975)	760	(91,648)	51,611	3,843	(5,565)		(3,036)		2,210		(188,800)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Snow Valley Nursing & Rehab Center# 0046185

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(8,981)	32,415	1,278		283			5,593		78		30,666	30
31	Amortization of Pre-Op. & Org.	(4,005)	4,005											31
32	Interest	(5,005)	130,111	18,783		3,419			983				148,291	32
33	Real Estate Taxes			616		67							683	33
34	Rent-Facility & Grounds		(156,000)	1,069							347		(154,584)	34
35	Rent-Equipment & Vehicles			755							4		759	35
36	Other (specify):*													36
37	TOTAL Ownership	(17,991)	10,531	22,501		3,769			6,576		429		25,815	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,592)		(8,860)	30,622	(1,234)		16,936	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(3,592)		(8,860)	30,622	(1,234)		16,936	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(164,966)	11,291	(69,147)	51,611	7,612	(9,157)		(5,320)	30,622	1,405		(146,049)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 156,000	Snow Valley Healthcare Properties LLC	100.00%	\$	(156,000)	1
2	V	33 Real Estate Income	19,663	Snow Valley Healthcare Properties LLC	100.00%	19,663		2
3	V	21 Bank Charges		Snow Valley Healthcare Properties LLC	100.00%	250	250	3
4	V	21 Replacement Tax		Snow Valley Healthcare Properties LLC	100.00%	510	510	4
5	V	30 Depreciation		Snow Valley Healthcare Properties LLC	100.00%	32,415	32,415	5
6	V	31 Amortization		Snow Valley Healthcare Properties LLC	100.00%	4,005	4,005	6
7	V	32 Interest Expense		Snow Valley Healthcare Properties LLC	100.00%	130,111	130,111	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 175,663			\$ 186,954	\$ * 11,291	14

* 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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 75	\$	75	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	167		167	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	155		155	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	637		637	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	989		989	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	730		730	20
21	V	19 Professional Fees	103,680	Extended Care Consulting, LLC	100.00%	3,157		(100,523)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	625		625	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	5,112		5,112	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	20		20	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	114		114	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	251		251	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,278		1,278	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	18,783		18,783	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	616		616	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	1,069		1,069	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	755		755	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 103,680			\$ 34,533	\$ *	(69,147)	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 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	2,424	\$	2,424	15
16	V	06 Maintenance (Direct)	549	Extended Care Consulting, LLC	100.00%	549			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	415		415	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	75		75	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	2,646		2,646	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	39,802		39,802	20
21	V	21 Office and Clerical (Direct)	22,280	Extended Care Consulting, LLC	100.00%	23,107		827	21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	6,810		6,810	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,177		3,177	23
24	V	22 Employee Benefits	4,565	Extended Care Consulting, LLC	100.00%			(4,565)	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		\$ 27,394			\$ 79,005	\$ *	51,611	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 17	\$	17	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	41		41	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	5		5	17
18	V	19 Professional Fees	28,153	Extended Care Clinical, LLC	100.00%	355		(27,798)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	2		2	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	302		302	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	299		299	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	15		15	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	283		283	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	3,419		3,419	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	67		67	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	1,299		1,299	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	188		188	27
28	V	10 Nursing Salary	3,957	Extended Care Clinical, LLC	100.00%	13,272		9,315	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	509		509	29
30	V	12 Social Service Salary	1,681	Extended Care Clinical, LLC	100.00%	4,457		2,776	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,235		2,235	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	11,538		11,538	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	2,286		2,286	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	2,005		2,005	34
35	V	22 Employee Benefits	1,191	Extended Care Clinical, LLC	100.00%			(1,191)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 34,982			\$ 42,594	\$ *	7,612	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 614	Xcel Supply, LLC	100.00%	\$ 557	\$ (56)
16	V	3 Housekeeping	15,031	Xcel Supply, LLC	100.00%	13,651	(1,380)
17	V	4 Laundry	5,479	Xcel Supply, LLC	100.00%	4,976	(503)
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%		
19	V	10 Nursing	38,373	Xcel Supply, LLC	100.00%	34,850	(3,524)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits	1,099	Xcel Supply, LLC	100.00%	998	(101)
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	39,116	Xcel Supply, LLC	100.00%	35,524	(3,592)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 99,712			\$ 90,555	\$ * (9,157)

* 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%	\$ 51,183	\$ 51,183	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	51,183	CCS Employee Benefits Group	100.00%		(51,183)	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		\$ 51,183			\$ 51,183	\$ *	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%	\$ 872	\$	872	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	48		48	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	74		74	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	4		4	18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	49		49	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	2,269		2,269	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	382		382	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	3,324		3,324	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	601		601	23
24	V	21 Office and Clerical	4,083	Vent Lease, LLC.	100.00%			(4,083)	24
25	V	39 Ancillary	8,860	Vent Lease, LLC.	100.00%			(8,860)	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		\$ 12,943			\$ 7,623	\$ *	(5,320)	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	39 THERAPY	\$ 114,154	TRICARE REHAB		\$ 144,776	\$ 30,622	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		\$ 114,154			\$ 144,776	\$ * 30,622	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 489	\$	489	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%	37		37	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	28		28	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	40		40	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	16		16	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	201		201	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	30		30	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	76		76	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	78		78	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%				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%	347		347	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	4		4	28
29	V	01 Dietary	2,195	Care Centers Health Systems, Inc.	100.00%	876		(1,319)	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	22 Employee Benefits		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	2,054	Care Centers Health Systems, Inc.	100.00%	820		(1,234)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	1,063		1,063	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,085		1,085	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	464		464	38
39	Total		\$ 4,249			\$ 5,654	\$ *	1,405	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.33	1.10%		\$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	0.61	1.10%	AI Sal/AI Fee	1,842	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	1.14	2.85%	Alloc. Salary	2,056	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,898		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization 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

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.

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	30	\$ 6,770	\$	15,217	\$ 75	1
2	02	Food	Patient Days	30	15,058		15,217	167	2
3	03	Housekeeping	Patient Days	30	14,059		15,217	155	3
4	05	Utilities	Patient Days	30	57,646		15,217	637	4
5	06	Maintenance	Patient Days	30	89,465		15,217	989	5
6	17	Administrative	Patient Days	30	66,000		15,217	730	6
7	19	Professional Fees	Patient Days	30	285,482		15,217	3,157	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		15,217	625	8
9	21	Office and Clerical	Patient Days	30	462,313		15,217	5,112	9
10	24	Seminar and Travel	Patient Days	30	1,768		15,217	20	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		15,217	114	11
12	26	Insurance	Patient Days	30	22,668		15,217	251	12
13	30	Depreciation	Patient Days	30	115,549		15,217	1,278	13
14	32	Interest	Patient Days	30	1,698,489		15,217	18,783	14
15	33	Real Estate Taxes	Patient Days	30	55,709		15,217	616	15
16	34	Rent - Building	Patient Days	30	96,636		15,217	1,069	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		15,217	755	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 34,533	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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	30	219,177	219,177	15,217	2,424	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905		549	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		15,217	415	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464		75	4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	15,217	2,646	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	15,217	39,802	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			23,107	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	15,217	6,810	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	15,217	3,177	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				\$ 5,530,203	\$ 4,838,529		\$ 79,005	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Clinical 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	03	Housekeeping	Patient Days	30	\$ 1,549	\$	15,217	\$ 17	1
2	05	Utilities	Patient Days	30	3,693		15,217	41	2
3	06	Maintenance	Patient Days	30	477		15,217	5	3
4	19	Professional Fees	Patient Days	30	32,105		15,217	355	4
5	20	Dues and Subscriptions	Patient Days	30	213		15,217	2	5
6	21	Office & Clerical	Patient Days	30	27,296		15,217	302	6
7	24	Travel and Seminar	Patient Days	30	27,079		15,217	299	7
8	26	Insurance	Patient Days	30	1,342		15,217	15	8
9	30	Depreciation	Patient Days	30	25,586		15,217	283	9
10	32	Interest	Patient Days	30	309,136		15,217	3,419	10
11	33	Real Estate Taxes	Patient Days	30	6,053		15,217	67	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	15,217	1,299	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		15,217	188	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	15,217	8,846	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	15,217	509	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	15,217	2,736	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		15,217	1,753	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	15,217	11,538	18
19	21	Office Salary	Patient Days	30	206,680	206,680	15,217	2,286	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		15,217	2,005	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	15,217	4,426	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		1,721	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			482	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 42,594	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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						557	1
2	3	Housekeeping						13,651	2
3	4	Laundry						4,976	3
4	6	Repairs & Maintenance							4
5	10	Nursing						34,850	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions							8
9	21	Office And Clerical							9
10	22	Employee Benefits						998	10
11	24	Seminars & Education							11
12	39	Ancillary						35,524	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							90,555	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	Employee Health Insurance	Direct Allocation			\$	\$		\$ 51,183	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				\$	\$		\$ 51,183	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	821,185	26	\$ 80,807	\$ 8,860	\$ 872	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	8,860	48	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	8,860	74	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	8,860	4	4
5	26	Insurance	Direct Billing	821,185	26	4,573	8,860	49	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	8,860	2,269	6
7	32	Interest	Direct Billing	821,185	26	35,420	8,860	382	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	15,217	3,324	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	15,217	601	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					\$ 706,114	\$	\$ 7,623	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 TriCare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		\$ 144,776	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				\$	\$		\$ 144,776	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers 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

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	01	Dietary	Gross Billable Income	3,421,940	26	72,652	23,050	489	1	
2	03	Housekeeping	Gross Billable Income	3,421,940	26		23,050		2	
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	23,050	37	3	
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	23,050	28	4	
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	23,050	40	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	23,050	16	6	
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	23,050	201	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	23,050	30	8	
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	23,050	76	9	
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	23,050	78	10	
11	32	Interest	Gross Billable Income	3,421,940	26		23,050		11	
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		23,050		12	
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	23,050	347	13	
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	23,050	4	14	
15	01	Dietary	Direct Billable Income	206,522	26	82,445	2,195	876	15	
16	02	Food	Direct Billable Income	2,784	26	1,111			16	
17	03	Housekeeping	Direct Billable Income		26				17	
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18	
19	22	Employee Benefits	Direct Billable Income	411	26	164			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20	
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	2,054	820	21	
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	23,050	1,063	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	23,050	1,085	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	23,050	464	24	
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 5,654	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	Bank of America		X	Mortgage			\$	\$ 1,092,444		\$ 130,111	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	LaSalle Bank		X	Line of Credit				651,128		19,050	6								
7	Allocated From EC Consult.		X							18,783	7								
8	See Supplemental Schedule									983	8								
9	TOTAL Facility Related						\$	\$ 1,743,572		\$ 168,927	9								
B. Non-Facility Related*																			
10	Interest Income		X							(5,005)	10								
11	Allocated From EC Clinical		X							3,419	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (1,586)	14								
15	TOTALS (line 9+line14)						\$	\$ 1,743,572		\$ 167,341	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:

01/01/09

Ending:

12/31/09

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 Vent Lease		X							983	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										983	14								
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.)

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.)

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: _____ 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>100,500</u>	<u>2003</u>	<u>\$ 139,765</u>	<u>1</u>
2	<u>Allocated From ECC 2201 Main/EC Clinical 2201 Main</u>			<u>4,059</u>	<u>2</u>
3	TOTALS	100,500		\$ 143,824	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2003		9,788		20	489	489	3,041	9
10	Various		2004		8,269		20	514	514	2,846	10
11	Various		2005		42,808		20	2,855	2,855	12,847	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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	
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	Related Building Company (Pages 12F & 12G)		1,243,335	30,889		31,083	194	214,990	67
68	Related Party Allocations (Pages 12H & 12I)		16,058	1,096		1,096		6,683	68
69	Financial Statement Depreciation			5,913			(5,913)		69
70	TOTAL (lines 4 thru 69)		\$ 1,320,258	\$ 37,898		\$ 36,037	\$ (1,861)	\$ 240,407	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 1,320,258	\$ 37,898		\$ 36,037	\$ (1,861)	\$ 240,407	1
2	Lovitt & Sons, Inc. - Concrete Sidewalk	2006	3,565		20	178	178	639	2
3	Painting (Transfer Expense From Home Office)	2007	17,949		20			17,949	3
4	Architectural Additions	2008	3,078		20	154	154	231	4
5	Drain Tile System Overhaul	2009	14,170		20	354	354	354	5
6	Stairwell Modifications	2009	11,500		20	240	240	240	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)		\$ 1,370,520	\$ 37,898		\$ 36,963	\$ (935)	\$ 259,820	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 1,370,520	\$ 37,898		\$ 36,963	\$ (935)	\$ 259,820
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 1,370,520	\$ 37,898		\$ 36,963	\$ (935)	\$ 259,820

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,370,520	\$ 37,898		\$ 36,963	\$ (935)	\$ 259,820	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)	\$ 1,370,520	\$ 37,898		\$ 36,963	\$ (935)	\$ 259,820	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,370,520	\$ 37,898		\$ 36,963	\$ (935)	\$ 259,820	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)	\$ 1,370,520	\$ 37,898		\$ 36,963	\$ (935)	\$ 259,820	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Building Company Information								1
2	Buildings:								2
3	51 Beds	1972	1,243,335	30,889	40	31,083	194	214,990	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Building Company Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$ 1,243,335	\$ 30,889		\$ 31,083	\$ 194	\$ 214,990	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	5,038	129	39	129		942	3
4	Allocated From Extended Care Clinical 2201 Main	2002	555	14	39	14		104	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	51	1	20	1		6	9
10	Allocated From Extended Care Consulting	2009	30	2	20	2		2	10
11									11
12	Allocated From Extended Care Consulting 2201 Main	2002	4,162	380	20	380		2,286	12
13	Allocated From Extended Care Consulting 2201 Main	2003	4,904	448	20	448		2,694	13
14	Allocated From Extended Care Consulting 2201 Main	2005	244	26	20	26		88	14
15	Allocated From Extended Care Consulting 2201 Main	2009	44	2	20	2		2	15
16									16
17	Allocated From Extended Care Clinical 2201 Main	2002	458	42	20	42		252	17
18	Allocated From Extended Care Clinical 2201 Main	2003	540	49	20	49		297	18
19	Allocated From Extended Care Clinical 2201 Main	2005	27	3	20	3		10	19
20	Allocated From Extended Care Clinical 2201 Main	2009	5		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

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:

01/01/09

Ending:

12/31/09

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	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 16,058	\$ 1,096		\$ 1,096	\$ 6,683	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 31,169	\$ 11,700	\$ 3,817	\$ (7,883)	10	\$ 23,667	71
72	Current Year Purchases	3,418	505	342	(163)	10	342	72
73	Fully Depreciated Assets	32,842				10	32,842	73
74								74
75	TOTALS	\$ 67,429	\$ 12,205	\$ 4,159	\$ (8,046)		\$ 56,851	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		Alloc. From EC Consulting	2009	\$ 3,556	\$ 56	\$ 56	\$	5	\$ 3,389	76
77		Alloc. From EC Clinical	2009	795	159	159		5	468	77
78		Alloc. From EC Health Sys.	2009	197	39	39		5	59	78
79										79
80	TOTALS			\$ 4,548	\$ 254	\$ 254	\$		\$ 3,916	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)	\$ 1,586,321	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,357	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,376	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,981)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 320,587	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	Architecture- Planning &	\$ 13,714	92
93	Consulting		93
94			94
95		\$ 13,714	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.

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	<u>Allocated From Extended Care Consulting</u>			<u>1,069</u>			5
6	<u>Allocated From Care Centers Health Systems</u>			<u>347</u>			6
7	TOTAL			\$ <u>1,416</u>			7

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: \$ 1,775 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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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		Contract	Total
		1	2		
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	\$		\$ 48,613	\$		\$ 48,613	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,199			13,199	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			62,587			62,587	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 prescrpts				57,413		57,413	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					14,976	50,837		65,813	13
14	TOTAL			\$		\$ 139,375	\$ 108,250		\$ 247,625	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: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 35,686	\$ 37,519	1
2	Cash-Patient Deposits	20,888	20,888	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	124,545	124,545	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,422	52,422	6
7	Other Prepaid Expenses	995	995	7
8	Accounts Receivable (owners or related parties)	21,470	21,470	8
9	Other(specify): <u>See Attached Schedule</u>	56,967	62,414	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 312,973	\$ 320,253	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	107,724	107,724	15
16	Equipment, at Historical Cost	26,202	33,268	16
17	Accumulated Depreciation (book methods)	(64,380)	(137,370)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	10,546	21,561	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 80,092	\$ 1,369,617	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 393,065	\$ 1,689,870	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 189,580	\$ 189,580	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,063	15,063	28
29	Short-Term Notes Payable	651,128	651,128	29
30	Accrued Salaries Payable	55,387	55,387	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,624	1,624	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,700	19,700	32
33	Accrued Interest Payable		8,740	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	3,588	32,005	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 936,070	\$ 973,227	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,092,444	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)	\$	\$ 1,092,444	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 936,070	\$ 2,065,671	46
47	TOTAL EQUITY(page 18, line 24)	\$ (543,005)	\$ (375,801)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 393,065	\$ 1,689,870	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (88,618)	1
2	Restatements (describe):		2
3	Office Expense/Pension Expense/Rounding	209	3
4	Due to Prior Owner Adjustment	13,973	4
5	Prior Year Dividends	27,556	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (46,880)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(486,603)	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	(9,522)	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)	\$ (496,125)	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)	\$ (543,005)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 2,578,827	1
2	Discounts and Allowances for all Levels	(463,109)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,115,718	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	391,210	6
7	Oxygen	1,674	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 392,884	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,875	13
14	Non-Patient Meals	1,044	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	63,004	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,256	19
20	Radiology and X-Ray	1,180	20
21	Other Medical Services	73,451	21
22	Laundry	384	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 150,194	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,005	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,005	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	690	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 690	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,664,491	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	506,966	31
32	Health Care	1,317,942	32
33	General Administration	844,199	33
B. Capital Expense			
34	Ownership	206,439	34
C. Ancillary Expense			
35	Special Cost Centers	247,625	35
36	Provider Participation Fee	27,923	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,151,094	40
41	Income before Income Taxes (line 30 minus line 40)**	(486,603)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (486,603)	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:

01/01/09

Ending:

12/31/09

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	2,356	2,473	\$ 84,971	\$ 34.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,007	5,916	176,420	29.82	3
4	Licensed Practical Nurses	10,503	11,406	279,711	24.52	4
5	CNAs & Orderlies	28,165	30,621	429,770	14.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,632	6,303	113,729	18.04	8
9	Activity Director	1,988	2,128	37,192	17.48	9
10	Activity Assistants	3,650	3,787	38,665	10.21	10
11	Social Service Workers	2,475	2,879	49,273	17.11	11
12	Dietician					12
13	Food Service Supervisor	1,985	2,226	46,971	21.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,199	2,572	35,384	13.76	15
16	Dishwashers	5,281	5,577	57,248	10.27	16
17	Maintenance Workers	1,434	1,508	24,985	16.57	17
18	Housekeepers	8,445	8,865	83,873	9.46	18
19	Laundry	1,961	2,197	37,210	16.94	19
20	Administrator	2,011	2,210	96,317	43.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,434	2,843	51,515	18.12	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)	85,526	93,511	\$ 1,643,234 *	\$ 17.57	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	84	\$ 4,073	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	750	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>		5,641		48
49	TOTAL (lines 35 - 48)	84	\$ 20,064		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 495	10-03	50
51	Licensed Practical Nurses	590	22,452	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	598	\$ 22,947		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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

0046185

Report Period Beginning: 01/01/09

Ending: 12/31/09

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 \$4,243
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,477 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 27,923
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,044
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- 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
- (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.