

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0046185</u></p> <p>Facility Name: <u>Snow Valley Nursing & Rehab Center</u></p> <p>Address: <u>5000 Lincoln Avenue</u> <u>Lisle</u> <u>60532</u> Number City Zip Code</p> <p>County: <u>Dupage</u></p> <p>Telephone Number: <u>(630) 852-5100</u> Fax # <u>(630) 852-5148</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/01/2003</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/10</u> to <u>12/31/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185 Report Period Beginning: 01/01/10 Ending: 12/31/10

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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>12,046</u>	<u>1,063</u>	<u>2,151</u>	<u>15,260</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>12,046</u>	<u>1,063</u>	<u>2,151</u>	<u>15,260</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.98%

D. How many bed-hold days during this year were paid by the Department? 404 (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 1,860

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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Snow Valley Nursing & Rehab Center # 0046185 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	140,283	20,795	7,385	168,463		168,463	619	169,082		1
2	Food Purchase		76,608		76,608		76,608	(1,819)	74,789		2
3	Housekeeping	66,680	13,789		80,469		80,469	(671)	79,798		3
4	Laundry	35,264	10,402		45,666		45,666	(350)	45,316		4
5	Heat and Other Utilities			62,354	62,354		62,354	(1,528)	60,826		5
6	Maintenance	41,523		140,744	182,267		182,267	2,857	185,124		6
7	Other (specify):*							515	515		7
8	TOTAL General Services	283,750	121,594	210,483	615,827		615,827	(376)	615,451		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,038,330	68,117	95,960	1,202,407		1,202,407	(2,654)	1,199,753		10
10a	Therapy	96,249			96,249		96,249	1,091	97,340		10a
11	Activities	94,044	6,649		100,693		100,693		100,693		11
12	Social Services	40,988		24,600	65,588		65,588	(41,985)	23,603		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,776	5,776		15
16	TOTAL Health Care and Programs	1,269,611	74,766	130,160	1,474,537		1,474,537	(37,772)	1,436,765		16
	C. General Administration										
17	Administrative	93,433			93,433		93,433	14,004	107,437		17
18	Directors Fees										18
19	Professional Services			169,840	169,840		169,840	(123,765)	46,075		19
20	Dues, Fees, Subscriptions & Promotions			33,386	33,386		33,386	(6,496)	26,890		20
21	Clerical & General Office Expenses	51,551	13,539	73,276	138,366		138,366	29,286	167,652		21
22	Employee Benefits & Payroll Taxes			305,749	305,749		305,749	(14,157)	291,592		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,917	3,917		3,917	415	4,332		24
25	Other Admin. Staff Transportation			2,594	2,594		2,594	202	2,796		25
26	Insurance-Prop.Liab.Malpractice			74,136	74,136		74,136	86	74,222		26
27	Other (specify):*							9,459	9,459		27
28	TOTAL General Administration	144,984	13,539	662,898	821,421		821,421	(90,966)	730,455		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,698,345	209,899	1,003,541	2,911,785		2,911,785	(129,114)	2,782,671		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: 01/01/10 Ending: 12/31/10

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			10,918	10,918		10,918	29,060	39,978			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,047	21,047		21,047	365	21,412			32
33	Real Estate Taxes			20,035	20,035		20,035	514	20,549			33
34	Rent-Facility & Grounds			157,636	157,636		157,636	(155,682)	1,954			34
35	Rent-Equipment & Vehicles			11,504	11,504		11,504	(2,500)	9,004			35
36	Other (specify):*											36
37	TOTAL Ownership			221,140	221,140		221,140	(128,243)	92,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,985	219,556	432,541		432,541	(22,039)	410,502			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):*			43,343	43,343		43,343	(43,343)				43
44	TOTAL Special Cost Centers		212,985	290,822	503,807		503,807	(65,382)	438,425			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,698,345	422,884	1,515,503	3,636,732		3,636,732	(322,739)	3,313,993			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	(1,199)	02		4
5	Telephone, TV & Radio in Resident Rooms	(1,858)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,167)	30		9
10	Interest and Other Investment Income	(744)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(53)	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	(3,281)	21		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	(23,273)	21		24
25	Fund Raising, Advertising and Promotional	(5,258)	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	(55,562)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (95,395)		\$	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)	(227,345)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (227,345)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (322,739)		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: 01/01/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (677)	02	1
2	Insurance Refund	(178)	26	2
3	Security Refund	(72)	06	3
4	Water Bill Refund	(25)	05	4
5	Theft Loss	(452)	21	5
6	Account Collection Expense	(408)	21	6
7	COPE Dues	(1,867)	20	7
8	Non-Allowable Expense	(43,343)	43	8
9	Annual Report	(250)	20	9
10	Website Fee	(12)	21	10
11	Building Company Amortization	(8,278)	31	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
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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	(55,562)		49

Snow Valley Nursing & Rehab Center

ID# 0046185

Report Period Beginning: 01/01/10

Ending: 12/31/10

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
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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:

01/01/10

Ending:

12/31/10

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			40		1,173		(536)			(58)		619	1
2	Food Purchase	(1,929)		110									(1,819)	2
3	Housekeeping			142		16					(829)		(671)	3
4	Laundry										(350)		(350)	4
5	Heat and Other Utilities	(1,883)		322		33							(1,528)	5
6	Maintenance	(72)		926	1,986	33					(16)		2,857	6
7	Other (specify):*				351	164							515	7
8	TOTAL General Services	(3,884)		1,540	2,337	1,419		(536)			(1,252)		(376)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					377					(3,031)		(2,654)	10
10a	Therapy					1,091							1,091	10a
11	Activities													11
12	Social Services				(19,965)	(22,020)							(41,985)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					1,320	4,456						5,776	15
16	TOTAL Health Care and Programs				(19,965)	(19,232)	4,456				(3,031)		(37,772)	16
	C. General Administration													
17	Administrative			656	2,547	10,801							14,004	17
18	Directors Fees													18
19	Professional Services			(97,445)		(26,320)							(123,765)	19
20	Fees, Subscriptions & Promotions	(7,375)		832		47							(6,496)	20
21	Clerical & General Office Expenses	(27,426)		3,886	50,842	1,984							29,286	21
22	Employee Benefits & Payroll Taxes				(9,594)		(4,456)				(107)		(14,157)	22
23	Inservice Training & Education													23
24	Travel and Seminar			41		374							415	24
25	Other Admin. Staff Transportation			202									202	25
26	Insurance-Prop.Liab.Malpractice	(178)		221		43							86	26
27	Other (specify):*				7,729	1,730							9,459	27
28	TOTAL General Administration	(34,979)		(91,607)	51,524	(11,341)	(4,456)				(107)		(90,966)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(38,863)		(90,067)	33,896	(29,154)		(536)			(4,390)		(129,114)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	(4,167)	31,805	1,196		226							29,060	30
31	Amortization of Pre-Op. & Org.	(8,278)	8,278											31
32	Interest	(744)	(5,483)	2,282		4,310							365	32
33	Real Estate Taxes			463		51							514	33
34	Rent-Facility & Grounds		(156,000)	318									(155,682)	34
35	Rent-Equipment & Vehicles			571								(3,071)	(2,500)	35
36	Other (specify):*													36
37	TOTAL Ownership	(13,189)	(121,400)	4,830		4,587						(3,071)	(128,243)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(1,469)	(9,656)	(1,272)	(3,228)	(6,414)	(22,039)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(43,343)											(43,343)	43
44	TOTAL Special Cost Centers	(43,343)						(1,469)	(9,656)	(1,272)	(3,228)	(6,414)	(65,382)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(95,395)	(121,400)	(85,237)	33,896	(24,567)		(2,005)	(9,656)	(1,272)	(7,618)	(9,485)	(322,739)	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	30 Depreciation Expense		Snow Valley Healthcare Properties LLC	100.00%	31,805	31,805	2
3	V	31 Amortization		Snow Valley Healthcare Properties LLC	100.00%	8,278	8,278	3
4	V	32 Interest	5,483	Snow Valley Healthcare Properties LLC	100.00%		(5,483)	4
5	V	33 Real Estate Income	20,035	Snow Valley Healthcare Properties LLC	100.00%	20,035		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 181,518			\$ 60,118	\$ * (121,400)	14

* 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	\$	Extended Care Consulting, LLC	100.00%	\$ 40	\$	40	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	110		110	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	142		142	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	322		322	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	926		926	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	656		656	20
21	V	19 Professional Fees	100,180	Extended Care Consulting, LLC	100.00%	2,735		(97,445)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	832		832	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	3,886		3,886	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	41		41	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	202		202	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	221		221	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,196		1,196	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	2,282		2,282	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	463		463	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	318		318	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	571		571	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 100,180			\$ 14,943	\$ *	(85,237)	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%	1,986	\$	1,986	15
16	V	06 Maintenance (Direct)	175	Extended Care Consulting, LLC	100.00%	175			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	332		332	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	19		19	18
19	V	12 Admission (Direct)		Extended Care Consulting, LLC	100.00%			(19,965)	19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%				20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	2,547		2,547	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	30,877		30,877	22
23	V	21 Office and Clerical (Direct)	19,965	Extended Care Consulting, LLC	100.00%	19,965		19,965	23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	5,585		5,585	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,144		2,144	25
26	V	22 Employee Benefits	9,594	Extended Care Consulting, LLC	100.00%			(9,594)	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		\$ 29,734			\$ 63,630	\$ *	33,896	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%	\$ 16	\$	16	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	33		33	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	33		33	17
18	V	19 Professional Fees	28,153	Extended Care Clinical, LLC	100.00%	1,833		(26,320)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	47		47	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	438		438	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	374		374	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	43		43	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	226		226	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	4,310		4,310	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	51		51	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	1,173		1,173	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	164		164	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	7,547		377	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,091		1,091	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	781		(22,020)	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,320		1,320	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	10,801		10,801	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	1,546		1,546	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	1,730		1,730	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 28,153			\$ 33,557	\$ *	(24,567)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$	Extended Care Clinical, LLC	100.00%	\$	\$	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10 Nursing Salary	6,442	Extended Care Clinical, LLC	100.00%	6,442		17
18	V	12 Social Service Salary	22,801	Extended Care Clinical, LLC	100.00%	22,801		18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,456	4,456	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22 Employee Benefits	4,456	Extended Care Clinical, LLC	100.00%		(4,456)	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		\$ 33,699			\$ 33,699	\$ *	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 Supplies, Supplements	\$ 1,207	Care Centers Health Systems, Inc.	100.00%	\$ 671	\$ (536)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense	3,307	Care Centers Health Systems, Inc.	100.00%	1,838	(1,469)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
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		\$ 4,514			\$ 2,509	\$ * (2,005)

* 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	\$ 204,170	TriCare Rehab	100.00%	\$ 194,514	\$ (9,656)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
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		\$ 204,170			\$ 194,514	\$ * (9,656)

* 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	6 R&M - Equipment	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$	15	
16	V	10 Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16	
17	V	39 Ancillary Expense	16,230	Reliable Medical of the Midwest, LLC	100.00%	14,958	(1,272)	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		\$ 16,230			\$ 14,958	\$ *	(1,272)	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	\$ 864	Xcel Supply, LLC	100.00%	\$ 807	\$	(58)	15
16	V	3 Housekeeping	12,435	Xcel Supply, LLC	100.00%	11,606		(829)	16
17	V	4 Laundry	5,251	Xcel Supply, LLC	100.00%	4,901		(350)	17
18	V	6 Repairs & Maintenance	242	Xcel Supply, LLC	100.00%	226		(16)	18
19	V	10 Nursing	45,486	Xcel Supply, LLC	100.00%	42,455		(3,031)	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	1,606	Xcel Supply, LLC	100.00%	1,499		(107)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%				25
26	V	39 Ancillary	48,436	Xcel Supply, LLC	100.00%	45,208		(3,228)	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		\$ 114,320			\$ 106,702	\$ *	(7,618)	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%	\$ 96,407	\$ 96,407
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	96,407	CCS Employee Benefits Group	100.00%		(96,407)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V	35 Matrix Leasing	\$ 5,714	Vent Lease LLC	100.00%	\$ 2,643	(3,071)
27	V	39 Ventilator Equipment	11,935	Vent Lease LLC	100.00%	5,521	(6,414)
28	V	39 Other Ancillary		Vent Lease LLC	100.00%		
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 114,056			\$ 104,571	\$ * (9,485)

* 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: 01/01/10 Ending: 12/31/10

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	0.38	0.81%		\$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	0.55	1.00%	AI Sal/AI Fee	1,613		2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.51	1.28%	Alloc. Salary	885		3
4	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.20	0.90%	Alloc. Salary	680		4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,178		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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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	1,512,273	34	\$ 3,931	\$ 15,260	\$ 40	1
2	02	Food	Patient Days	1,512,273	34	10,940	15,260	110	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059	15,260	142	3
4	05	Utilities	Patient Days	1,512,273	34	31,923	15,260	322	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744	15,260	926	5
6	17	Administrative	Patient Days	1,512,273	34	65,000	15,260	656	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007	15,260	2,735	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419	15,260	832	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083	15,260	3,886	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022	15,260	41	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982	15,260	202	11
12	26	Insurance	Patient Days	1,512,273	34	21,934	15,260	221	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510	15,260	1,196	13
14	32	Interest	Patient Days	1,512,273	34	226,162	15,260	2,282	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910	15,260	463	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555	15,260	318	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569	15,260	571	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,480,749	\$	\$ 14,943	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	34	196,794	196,794	15,260	1,986	1
2	06	Maintenance (Direct)	Direct	34	32,478	32,478		175	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	34	32,885		15,260	332	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	34	3,607			19	4
5	12	Admission (Direct)	Direct	34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct	34	5,270				6
7	17	Administrative (Pooled)	Patient Days	34	252,448	252,448	15,260	2,547	7
8	21	Office and Clerical (Pooled)	Patient Days	34	3,059,876	3,059,876	15,260	30,877	8
9	21	Office and Clerical (Direct)	Direct	34	771,063	771,063		19,965	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	34	553,505		15,260	5,585	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	34	94,865			2,144	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				\$ 5,054,827	\$ 4,364,695		\$ 63,630	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	34	\$ 1,549	\$	15,260	\$ 16	1
2	05	Utilities	Patient Days	34	3,268		15,260	33	2
3	06	Maintenance	Patient Days	34	3,240		15,260	33	3
4	19	Professional Fees	Patient Days	34	181,624		15,260	1,833	4
5	20	Dues and Subscriptions	Patient Days	34	4,624		15,260	47	5
6	21	Office & Clerical	Patient Days	34	43,370		15,260	438	6
7	24	Travel and Seminar	Patient Days	34	37,025		15,260	374	7
8	26	Insurance	Patient Days	34	4,213		15,260	43	8
9	30	Depreciation	Patient Days	34	22,389		15,260	226	9
10	32	Interest	Patient Days	34	427,165		15,260	4,310	10
11	33	Real Estate Taxes	Patient Days	34	5,058		15,260	51	11
12	01	Dietary Salary	Patient Days	34	116,221	116,221	15,260	1,173	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	34	16,288		15,260	164	13
14	10	Nursing Salary	Patient Days	34	747,870	747,870	15,260	7,547	14
15	10a	Rehab Salary	Patient Days	34	108,151	108,151	15,260	1,091	15
16	12	Social Service Salary	Patient Days	34	77,377	77,377	15,260	781	16
17	15	Emp. Ben. - Healthcare	Patient Days	34	130,816		15,260	1,320	17
18	17	Administration Salary	Patient Days	34	1,070,339	1,070,339	15,260	10,801	18
19	21	Office Salary	Patient Days	34	153,206	153,206	15,260	1,546	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	34	171,480		15,260	1,730	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,325,274	\$ 2,273,164		\$ 33,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	01	Dietary Salary	Direct Allocation		\$ 15,960	\$ 15,960		\$	1
2	07	Emp. Ben. - General	Direct Allocation		1,662				2
3	10	Nursing Salary	Direct Allocation		495,330	495,330		6,442	3
4	12	Social Service Salary	Direct Allocation		274,597	274,597		22,801	4
5	15	Emp. Ben. - Healthcare	Direct Allocation		94,697			4,456	5
6	17	Administration Salary	Direct Allocation		82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation		10,053				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				\$ 974,688	\$ 868,276		\$ 33,699	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Supplies, Supplements	Direct Allocation		\$	\$		\$ 671	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					1,838	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				\$	\$		\$ 2,509	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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	39	Therapy	Direct Allocation		\$	\$		\$ 194,514	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				\$	\$		\$ 194,514	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue
 City / State / Zip Code Des Plaines, Illinois 60018-5909
 Phone Number (847) 566-0800
 Fax Number (

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	6	R&M - Equipment	Direct Allocation		\$	\$		\$	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					14,958	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				\$	\$		\$ 14,958	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$		\$ 807	1
2	3	Housekeeping	Direct Allocation					11,606	2
3	4	Laundry	Direct Allocation					4,901	3
4	6	Repairs & Maintenance	Direct Allocation					226	4
5	10	Nursing	Direct Allocation					42,455	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					1,499	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					45,208	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					\$		\$ 106,702	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

CCS Emp Ben / Vent Lease

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847)905-4000 / (847) 674-1180

Fax Number

(847)905-4040 / (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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 96,407	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11	35	Matrix Leasing	Direct Allocation		\$	\$		\$ 2,643	11
12	39	Ventilator Equipment	Direct Allocation					5,521	12
13	39	Other Ancillary	Direct Allocation						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				\$	\$		\$ 104,571	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending:

12/31/10

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										1									
2										2									
3										3									
4										4									
5	See Supplemental Schedule									5									
Working Capital																			
6	LaSalle Bank		X	Line of Credit			143,600			21,047	6								
7	Allocated From EC Consulting		X							2,282	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related					\$	\$ 143,600			\$ 23,329	9								
B. Non-Facility Related*																			
10	Interest Income		X							(744)	10								
11	Interest Income- Bldg Co.		X							(5,483)	11								
12	Allocated From EC Clinical		X							4,310	12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related					\$	\$			\$ (1,917)	14								
15	TOTALS (line 9+line14)					\$	\$ 143,600			\$ 21,412	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:

01/01/10

Ending:

12/31/10

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										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		\$	19,700	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.)		\$	19,897	2
3. Under or (over) accrual (line 2 minus line 1).		\$	197	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	20,352	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.		\$	20,549	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	16,945	8
	2006	17,659	9
	2007	17,904	10
	2008	18,762	11
	2009	19,383	12
2010 Accrual= \$19,383 X 1.05 = \$20,352			
Allocated From Extended Care Consulting: \$463			
Allocated From Extended Care Clinical \$51			

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$		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

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>100,500</u>	<u>2003</u>	<u>\$ 139,765</u>	<u>1</u>
2	<u>Allocated From ECC 2201 Main/EC Clinical 2201 Main</u>			<u>3,703</u>	<u>2</u>
3	TOTALS	100,500		\$ 143,468	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snow Valley Nursing & Rehab Center

0046185

Report Period Beginning:

01/01/10

Ending:

12/31/10

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		2003	9,788		20	489	489	3,531
10	Various		2004	8,269		20	514	514	3,359
11	Various		2005	42,808		20	2,855	2,855	15,702
12	Various		2006	3,565		20	178	178	817
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,243,335	30,889		31,083	194	246,073	67
68		14,922	1,016		1,016		7,114	68
69			9,331			(9,331)		69
70		\$ 1,322,687	\$ 41,236		\$ 36,136	\$ (5,100)	\$ 276,595	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,322,687	\$ 41,236		\$ 36,136	\$ (5,100)	\$ 276,595	1
2	Painting (Transfer Expense From Home Office)	2007	17,949		20			17,949	2
3	Architectural Additions	2008	3,078		20	154	154	385	3
4	Drain Tile System Overhaul	2009	14,170		20	709	709	1,063	4
5	Stairwell Modifications	2009	11,500		20	575	575	815	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)		\$ 1,369,384	\$ 41,236		\$ 37,573	\$ (3,663)	\$ 296,806	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		\$ 1,369,384	\$ 41,236		\$ 37,573	\$ (3,663)	\$ 296,806	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		\$ 1,369,384	\$ 41,236		\$ 37,573	\$ (3,663)	\$ 296,806	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		\$ 1,369,384	\$ 41,236		\$ 37,573	\$ (3,663)	\$ 296,806	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		\$ 1,369,384	\$ 41,236		\$ 37,573	\$ (3,663)	\$ 296,806	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		\$ 1,369,384	\$ 41,236		\$ 37,573	\$ (3,663)	\$ 296,806	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)	\$ 1,369,384	\$ 41,236		\$ 37,573	\$ (3,663)	\$ 296,806	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	246,073	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	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	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	\$ 246,073	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	4,597	118	39	118		977	3
4	Allocated From Extended Care Clinical 2201 Main	2002	506	13	39	13		108	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	46	2	20	2		9	9
10	Allocated From Extended Care Consulting	2009	28	1	20	1		3	10
11	Allocated From Extended Care Consulting	2010	272	14	20	14		14	11
12									12
13	Allocated From Extended Care Consulting 2201 Main	2002	3,797	347	20	347		2,433	13
14	Allocated From Extended Care Consulting 2201 Main	2003	4,475	409	20	409		2,867	14
15	Allocated From Extended Care Consulting 2201 Main	2005	222	24	20	24		104	15
16	Allocated From Extended Care Consulting 2201 Main	2009	40	2	20	2		4	16
17									17
18	Allocated From Extended Care Clinical 2201 Main	2002	418	38	20	38		268	18
19	Allocated From Extended Care Clinical 2201 Main	2003	493	45	20	45		316	19
20	Allocated From Extended Care Clinical 2201 Main	2005	24	3	20	3		11	20
21	Allocated From Extended Care Clinical 2201 Main	2009	4		20				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	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)		\$ 14,922	\$ 1,016		\$ 1,016	\$	7,114	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	\$ 22,194	\$ 2,730	\$ 2,226	\$ (504)	10	\$ 14,987	71
72	Current Year Purchases	147	15	15		10	15	72
73	Fully Depreciated Assets	41,953				10	41,953	73
74								74
75	TOTALS	\$ 64,294	\$ 2,745	\$ 2,241	\$ (504)		\$ 56,955	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 EC Consulting	2010	\$ 3,245	\$ 51	\$ 51		5	\$ 3,143	76
77		Allocated From EC Clinical	2010	564	113	113		5	263	77
78										78
79										79
80	TOTALS			\$ 3,809	\$ 164	\$ 164			\$ 3,406	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)	\$ 1,580,954	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,145	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,978	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,167)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 357,168	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.

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	Storage Unit Rental				1,636			5
6	Allocated From Extended Care Consulting				318			6
7	TOTAL				\$ 1,954			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: \$ 9,004 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. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

* 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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 83,416							\$ 83,416	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					31,533							31,533	2	
3	Licensed Recreational Therapist		hrs													3	
4	Licensed Physical Therapist	39 - 03	hrs					89,221							89,221	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							120,807					120,807	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>							15,386		92,178					107,564	13	
14	TOTAL			\$				\$ 219,556		\$ 212,985				\$	432,541	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

0046185

Report Period Beginning: 01/01/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 89,666	\$ 179,224	1
2	Cash-Patient Deposits	10,408	10,408	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	197,289	197,289	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,299	92,299	6
7	Other Prepaid Expenses	167	167	7
8	Accounts Receivable (owners or related parties)	30,992	30,992	8
9	Other(specify): <u>See Attached Schedule</u>	62,584	72,148	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 483,405	\$ 582,527	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	121,438	121,438	15
16	Equipment, at Historical Cost	26,202	33,268	16
17	Accumulated Depreciation (book methods)	(75,298)	(180,093)	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	13,283	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 82,888	\$ 1,332,330	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 566,293	\$ 1,914,857	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 527,377	\$ 527,377	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,037	13,037	28
29	Short-Term Notes Payable	143,600	143,600	29
30	Accrued Salaries Payable	61,574	61,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,037	2,037	31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,352	20,352	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	4,135	609,645	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 772,112	\$ 1,377,622	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>		506,450	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 506,450	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 772,112	\$ 1,884,072	46
47	TOTAL EQUITY(page 18, line 24)	\$ (205,819)	\$ 30,785	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 566,293	\$ 1,914,857	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (543,005)	1
2	Restatements (describe):		2
3	2009 Dividends Paid	9,522	3
4	Rounding Adjustment	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (533,479)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(772,340)	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	1,100,000	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)	\$ 327,660	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)	\$ (205,819)	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: 01/01/10

Ending: 12/31/10

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		2	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,784,239	1
2	Discounts and Allowances for all Levels	(758,593)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,025,646	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	642,837	6
7	Oxygen	1,055	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 643,892	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	1,491	13
14	Non-Patient Meals	1,199	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	120,658	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,321	19
20	Radiology and X-Ray	2,200	20
21	Other Medical Services	59,289	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 193,158	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	744	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 744	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	952	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 952	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,864,392	30

1		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	615,827	31
32	Health Care	1,474,537	32
33	General Administration	821,421	33
B. Capital Expense			
34	Ownership	221,140	34
C. Ancillary Expense			
35	Special Cost Centers	475,884	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)*	\$ 3,636,732	40
41	Income before Income Taxes (line 30 minus line 40)**	(772,340)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (772,340)	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: 01/01/10

Ending:

12/31/10

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	1,508	1,628	\$ 61,861	\$ 38.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,666	10,361	293,368	28.31	3
4	Licensed Practical Nurses	8,194	9,139	225,955	24.72	4
5	CNAs & Orderlies	28,717	31,309	457,146	14.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,799	5,321	96,249	18.09	8
9	Activity Director	1,956	2,039	41,082	20.15	9
10	Activity Assistants	4,794	5,014	52,962	10.56	10
11	Social Service Workers	1,856	2,084	40,988	19.67	11
12	Dietician					12
13	Food Service Supervisor	2,028	2,327	45,121	19.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,685	3,018	41,166	13.64	15
16	Dishwashers	4,642	5,095	53,996	10.60	16
17	Maintenance Workers	1,991	2,235	41,523	18.58	17
18	Housekeepers	7,001	7,190	66,680	9.27	18
19	Laundry	1,834	1,961	35,264	17.98	19
20	Administrator	2,066	2,318	93,433	40.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,334	2,635	51,551	19.56	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)	85,071	93,674	\$ 1,698,345 *	\$ 18.13	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	149	\$ 7,385	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	112	4,929	10-03	38
39	Pharmacist Consultant	Monthly	3,057	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	31	1,798	12-03	45
46	Other(specify)				46
47	<u>Contracted Director of Nursing</u>	552	20,700	10-03	47
48	<u>See Attached</u>		29,244		48
49	TOTAL (lines 35 - 48)	844	\$ 76,713		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	383	\$ 21,946	10-03	50
51	Licensed Practical Nurses	963	38,886	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,346	\$ 60,832		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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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:

01/01/10

Ending:

12/31/10

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. IL Council on LTC \$4,164
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,995 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. \$ 1,199
- (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% ln14
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.