FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0037838

Facility Name: Oregon Healthcare Center

Address: 881 South 10th Street (Number) Oregon (City) 61061 (Zip Code)

County: Ogle

Telephone Number: (815) 732-7994 **Fax #** (815) 732-3733

HFS ID Number:

Date of Initial License for Current Owners: 03/01/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	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	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	383	101	1,545	2,029	8
9	SNF/PED					9
10	ICF	12,727	5,888	2	18,617	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,110	5,989	1,547	20,646	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.39%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,545

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	184,334	9,375	4,609	198,318		198,318		198,318			1
2	Food Purchase		126,703		126,703		126,703	(2,853)	123,850			2
3	Housekeeping	139,742	43,856		183,598		183,598	58	183,656			3
4	Laundry	67,164	4,352		71,516		71,516		71,516			4
5	Heat and Other Utilities			108,195	108,195		108,195	869	109,064			5
6	Maintenance	28,687	41,550	7,120	77,357		77,357	371	77,728			6
7	Other (specify):*											7
8	TOTAL General Services	419,927	225,836	119,924	765,687		765,687	(1,555)	764,132			8
	B. Health Care and Programs											
9	Medical Director			4,875	4,875		4,875		4,875			9
10	Nursing and Medical Records	909,175	28,878	703	938,756		938,756	(220)	938,536			10
10a	Therapy			205,765	205,765		205,765		205,765			10a
11	Activities	57,246	5,020		62,266		62,266		62,266			11
12	Social Services	26,507			26,507		26,507		26,507			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	992,928	33,898	211,343	1,238,169		1,238,169	(220)	1,237,949			16
	C. General Administration											
17	Administrative	84,836		189,600	274,436		274,436	(145,697)	128,739			17
18	Directors Fees											18
19	Professional Services			51,450	51,450		51,450	12,520	63,970			19
20	Dues, Fees, Subscriptions & Promotions			12,737	12,737		12,737	(2,572)	10,165			20
21	Clerical & General Office Expenses	111,914		33,182	145,096		145,096	30,681	175,777			21
22	Employee Benefits & Payroll Taxes			214,330	214,330		214,330	3,033	217,363			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,779	2,779		2,779	30	2,809			24
25	Other Admin. Staff Transportation			1,881	1,881		1,881	674	2,555			25
26	Insurance-Prop.Liab.Malpractice			9,106	9,106		9,106	314	9,420			26
27	Other (specify):* Mgmt Alloc of Benefit							8,975	8,975			27
28	TOTAL General Administration	196,750		515,065	711,815		711,815	(92,042)	619,773			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,609,605	259,734	846,332	2,715,671		2,715,671	(93,817)	2,621,854			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 Oregon Healthcare Center #0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,967	28,967		28,967	29,409	58,376			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							44,542	44,542			32
33	Real Estate Taxes			38,417	38,417		38,417	1,868	40,285			33
34	Rent-Facility & Grounds			186,000	186,000		186,000	(186,000)				34
35	Rent-Equipment & Vehicles							636	636			35
36	Other (specify):*											36
37	TOTAL Ownership			253,384	253,384		253,384	(109,545)	143,839			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,105		65,105		65,105		65,105			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,940	56,940		56,940		56,940			42
43	Other (specify):* Non-Allowable Cos			14,971	14,971		14,971	(14,971)				43
44	TOTAL Special Cost Centers		65,105	71,911	137,016		137,016	(14,971)	122,045			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,609,605	324,839	1,171,627	3,106,071		3,106,071	(218,333)	2,887,738			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,353)	30		9
10	Interest and Other Investment Income	46,656	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(217)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,090)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,824)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	1,188	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 33,960		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(252,293)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (252,293)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (218,333)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center

ID# 0037838

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (5,272)	43	1
2	X Ray Expense Med A	(1,742)	43	2
3	Trust Fees	(250)	43	3
4	Gain / Loss on Partnership	11,085	43	4
5	Chamber of Commerce	(222)	20	5
6	COPE Fees	(2,411)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	1,188		49

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Oregon Associates	100.00%	$ 301	$ 301	1
2	V	30	Depreciation		Oregon Associates	100.00%	32,028	32,028	2
3	V	32	Interest	46,656	Oregon Associates	100.00%	45,631	(1,025)	3
4	V	32	Amortization-Mortgage Costs		Oregon Associates	100.00%	3,436	3,436	4
5	V	34	Rent	186,000	Oregon Associates	100.00%		(186,000)	5
6	V	43	Other	11,085	Oregon Associates	100.00%	1,824	(9,261)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 243,741			$ 83,220	$ * (160,521)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center, Inc.
Provider # : 0037838
12/31/2010

Schedule 6A

VII. Related Parties - Page 6

		Shares	Ownership %
1000	Sheldon Wolfe	3,174.00	31.74%
1001	Albert Milstein	3,173.00	31.73%
1002	Ronnie Klein as Trustee	1,586.50	15.87%
1003	Wanda Bowling	240.00	2.04%
1004	Moshe Herman	240.00	2.04%
1005	Kenneth Klein	1,586.50	15.87%
		10,000.00	99.29%

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center, Inc.
Provider # : 0037838
12/31/2010

Schedule 6B

VII. Related Parties - Page 6

Related Nursing Homes	City
In State:	
Cahokia Nursing & Rehab	Cahokia
Caseyville Nursing & Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing & Rehab	East St. Louis
Out of State :	
Rosewood Health & Rehab Center	Independence, MO
Beauvais Manor Healthcare & Rehab	St. Louis, MO
Hillside Manor Healthcare & Rehab	St. Louis, MO
Rancho Manor Healthcare & Rehab	Florissant, MO

Other Related Business Entities

	Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
	S.W. Management Co.	Skokie	Bookkeeping/Management Company
	S&E Medical Supply Co.	Skokie	Medical Supplies
*	SFO Associates	Skokie	Finance Company

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Management Co.	100.00%	$ 100	$ 100	15
16	V	3	Housekeeping		SW Management Co.	100.00%	58	58	16
17	V	5	Heat and Other Utilities		SW Management Co.	100.00%	869	869	17
18	V	6	Maintenance		SW Management Co.	100.00%	371	371	18
19	V	17	Administrative	189,600	SW Management Co.	100.00%	43,903	(145,697)	19
20	V	19	Professional Services		SW Management Co.	100.00%	1,242	1,242	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	61	61	21
22	V	21	Clerical & General Office Expense		SW Management Co.	100.00%	30,681	30,681	22
23	V	24	Travel and Seminar		SW Management Co.	100.00%	30	30	23
24	V	25	Other Admin Staff Transportation		SW Management Co.	100.00%	674	674	24
25	V	26	Insurance-Prop. Liab. Malpractice		SW Management Co.	100.00%	314	314	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.	100.00%	8,975	8,975	26
27	V	30	Depreciation		SW Management Co.	100.00%	1,734	1,734	27
28	V	32	Interest		SW Management Co.	100.00%	40	40	28
29	V	33	Real Estate Taxes		SW Management Co.	100.00%	1,868	1,868	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.	100.00%	636	636	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			$ 189,600			$ 91,556	$ * (98,044)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 618	S & E Medical Supply Co.	100.00%	$ 698	$ 80	15
16	V	10	Medical Supplies	505	S & E Medical Supply Co.	100.00%	285	(220)	16
17	V	3	Housekeeping	511	S & E Medical Supply Co.	100.00%	511		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			$ 1,634			$ 1,494	$ * (140)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	SFO Associates	0.00%	$ 10,977	$ 10,977	15
16	V	21	Clerical & General Office		SFO Associates	0.00%			16
17	V	32	Interest-Bonds	45,631	SFO Associates	0.00%	41,066	(4,565)	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			$ 45,631			$ 52,043	$ * 6,412	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	31.74	See Schedule 7A	3	7.14	Salary	$ 14,071	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative	15.87	See Schedule 7B	4	8.00	Salary&Fees	15,760	17,3&17,7	2
3	Moshe Herman	CFO	Administrative	2.40	See Schedule 7C	3	7.14	Salary	14,071	L17, C7	3
4											4
5											5
6											6
7			Note : All individuals work in excess of 40 hours per week.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,902		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 Oregon Healthcare Center # 0037838 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 [X] NO [ ]

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

Name of Related Organization: SW Management Co.
Street Address: 7434 North Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	742,930	12	$ 1,959	$	37,960	$ 100	1
2	3	Housekeeping	Bed Days Available	742,930	12	1,125		37,960	58	2
3	5	Heat and Other Utilities	Bed Days Available	742,930	12	17,016		37,960	869	3
4	6	Maintenance	Bed Days Available	742,930	12	7,264		37,960	371	4
5	19	Professional Services	Bed Days Available	742,930	12	24,273		37,960	1,242	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	742,930	12	1,198		37,960	61	6
7	21	Clerical & General Office Exp	Bed Days Available	742,930	12	600,468	509,094	37,960	30,681	7
8	24	Travel and Seminar	Bed Days Available	742,930	12	594		37,960	30	8
9	25	Other Admin. Staff Transport.	Bed Days Available	742,930	12	13,194		37,960	674	9
10	26	Insurance-Prop. Liab. & Malp.	Bed Days Available	742,930	12	6,148		37,960	314	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	742,930	12	175,644		37,960	8,975	11
12	32	Interest	Bed Days Available	742,930	12	778		37,960	40	12
13	33	Real Estate Taxes	Bed Days Available	742,930	12	36,555		37,960	1,868	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	742,930	12	12,454		37,960	636	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	84	12	394,000	394,000	6	28,143	17
18	17	Administrative	Avg. Hours Worked	50	6	197,000	197,000	4	15,760	18
19										19
20	30	Depreciation	Direct Cost	33,940					1,734	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,489,670	$ 1,100,094		$ 91,556	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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 [X] NO [ ]

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

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 698	1
2	10	Medical Supplies	Direct Cost						285	2
3	3	Housekeeping	Direct Cost						511	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					$	$		$ 1,494	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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 [X] NO [ ]

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

Name of Related Organization: SFO Associates
Street Address: 7434 North Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	$ 35,675	$	2,000,000	$ 10,977	1
2	21	Clerical & General Office	Note Receivable	6,500,000	3			2,000,000		2
3	32	Interest-Bonds	Note Receivable	6,500,000	3	133,465		2,000,000	41,066	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					$ 169,140	$		$ 52,043	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Oregon Associates	X		Bonds	Annual Pmt	7/1/04	$ 2,000,000	$ 584,616	8/15/17	Variable	$ 41,066	1
2	(Payable to SFO Assoc)				of $92,408							2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,000,000	$ 584,616			$ 41,066	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			3,436	10
11								Allocated from Mgmt Co.			40	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,476	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 584,616			$ 44,542	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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 Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 37,100	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.)	2009	$ 37,217	2
3. Under or (over) accrual (line 2 minus line 1).		$ 117	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,300	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.)	Mgmt Co.	$ 253	5
	Allocated from Management Co.	1,615	
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.		$ 40,285	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	32,052	8
2006	32,862	9
2007	33,979	10
2008	36,033	11
2009	37,217	12

RE Tax Accrual = 37,217 X 1.03 = 38,334. Use 38,300.

	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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oregon Healthcare Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0037838

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-04-476-009	Long Term Care Property	$ 37,217.02	$ 37,217.02
2.	10-28-412-049-0000	SW Management Allocation	$ 32,484.00	$ 1,615.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,701.02	$ 38,832.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	130,680	1992	$ 50,000	1
2					2
3	TOTALS	130,680		$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104		1992	1992	$ 1,008,880	$	40	$ 25,222	$ 25,222	$ 475,014	4
5											5
6	SW Management Allocation		1995		22,116		39	632	632	9,892	6
7											7
8											8
	Improvement Type**										
9	Various			1992	6,160		20			6,160	9
10	Various			1993	26,517	320	20	1,327	1,007	23,474	10
11	Various			1994	5,324		20	266	266	4,643	11
12	Various			1995	3,498		20	175	175	2,726	12
13	Various			1996	2,042	52	20	102	50	1,462	13
14	Various			1997	2,880	170	20	144	(26)	1,956	14
15	Various			1998	65,055	933	20	3,253	2,320	42,815	15
16	Various			1999	36,058	741	20	1,803	1,062	21,260	16
17											17
18	Model 10Kpa Code A/R			2001	1,189		20	59	59	560	18
19	Generator Repair			2001	1,010		20	51	51	464	19
20	Motor			2001	783		20	39	39	378	20
21	Glass Thermo Unit			2001	868		20	43	43	412	21
22	Install Board			2001	816		20	41	41	382	22
23	Gas Controller			2001	739		20	37	37	342	23
24	Clutch & Output Brd			2001	1,138		20	57	57	526	24
25	Vinyl Flooring			2001	912		20	46	46	453	25
26											26
27	Air Conditioners			2002	1,470		20	74	74	809	27
28	Air Conditioners			2002	1,366		20	68	68	694	28
29	Wall-Replaced			2002	5,000	91	20	250	159	2,146	29
30											30
31	Roof Exhaust Fan			2003	3,128		10	313	313	2,346	31
32	Condensor walk - in Freezer			2003	3,193		7	304	304	3,193	32
33	Radiator			2003	3,473		10	347	347	2,518	33
34	Hot Water Repair			2003	1,610		20	81	81	591	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2004	$ 15,850	$ 559	20	$ 793	$ 234	$ 5,152	37
38	Counter tops	2004	4,668		20	233	233	1,517	38
39	Nurses Station	2004	1,290		20	65	65	420	39
40	Basin	2004	7,500	192	20	375	183	2,438	40
41									41
42	Flooring	2005	3,703	135	20	185	50	1,018	42
43	Fire Alarm System	2005	1,932	70	20	97	27	532	43
44	Wanderguard	2005	1,632	59	10	163	104	897	44
45	Air Conditioners	2005	1,008	97	10	101	4	555	45
46									46
47	Vertical Rods with Panic Bars	2006	3,036	152	20	152	(0)	683	47
48	Smoke Stops-Attic	2006	1,140		20	57	57	257	48
49	Sidewalks	2006	5,106	354	20	255	(99)	1,149	49
50	Air Conditioners	2006	5,430	626	20	272	(355)	1,222	50
51	Sprinkler System	2006	62,467	2,326	20	3,123	797	14,055	51
52	Damper Switches - Sprinkler Systems	2006	1,505		20	75	75	339	52
53									53
54	Walk-in Freezer Condensing Unit	2007	6,016	218	20	301	83	1,051	54
55	Remodel Bathrooms	2009	14,939	543	20	747	204	1,120	55
56	Glue down carpet	2009	3,287	120	20	164	44	247	56
57									57
58	Rooftop A/C Unit	2010	13,256	261	20	331	70	331	58
59	Patio & Sidewalk	2010	3,575	3,575	20	89	(3,486)	89	59
60									60
61	SW Management allocation - Leasehold Improvements	1995	2,475		20	124	124	2,106	61
62	SW Management allocation - Leasehold Improvements	1996	412		20	21	21	300	62
63	SW Management allocation - Leasehold Improvements	1997	478		20	24	24	382	63
64	SW Management allocation - Leasehold Improvements	1998	409		20	20	20	260	64
65	SW Management allocation - Leasehold Improvements	1999	1,134		20	57	57	629	65
66	SW Management allocation - Leasehold Improvements	2005	2,347		20	117	117	645	66
67	SW Management allocation - Leasehold Improvements	2007	1,328		20	66	66	232	67
68	SW Management allocation - Leasehold Improvements	2009	2,773		20	139	139	208	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,373,921	$ 11,594		$ 42,878	$ 31,284	$ 643,047	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 54,880	$ 1,470	$ 5,490	$ 4,020	10	$ 19,627	71
72	Current Year Purchases	14,287	14,287	715	(13,572)	10	715	72
73	Fully Depreciated Assets	356,962					356,962	73
74	Allocated from Management Co.	6,983		142	142	10	5,401	74
75	TOTALS	$ 433,112	$ 15,757	$ 6,347	$ (9,410)		$ 382,705	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	Resident Care	Wheelchair lift for van	2003	$ 4,635	$	$ 464	$ 464	10	$ 3,400	76
77	Resident Care	E-350 Van	2003	26,099		932	932	7	26,099	77
78	Resident Care	2008 Chevy Van & lift	2007	36,812	1,616	7,362	5,746	5	25,768	78
79	Allocated from Management	Infiniti	2010	3,929		393	393	5	393	79
80	TOTALS			$ 71,475	$ 1,616	$ 9,151	$ 7,535		$ 55,660	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)	$ 1,928,508	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,967	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 58,376	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,409	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,081,412	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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: ____ *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
(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	Allocated from Management Co.		$	$ 636	17
18					18
19					19
20					20
21	TOTAL		$	$ 636	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,067	$ 119,528	$	1,067	$ 119,528	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		24	573		24	573	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		764	79,434		764	79,434	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				65,105		65,105	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	1,855	$ 199,535	$ 65,105	1,855	$ 264,640	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 Oregon Healthcare Center **#** 0037838 **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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 170,532	$ 170,532	1
2	Cash-Patient Deposits	16,658	16,658	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,017)	304,479	304,479	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,865	1,865	6
7	Other Prepaid Expenses		331	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	540,318	1,725,481	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,033,852	$ 2,219,346	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,030,996	14
15	Leasehold Improvements, at Historical Cost	245,038	342,925	15
16	Equipment, at Historical Cost	349,756	504,587	16
17	Accumulated Depreciation (book methods)	(408,280)	(1,081,412)	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 (spe See Schedule 17A		100,012	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 186,514	$ 947,108	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,220,366	$ 3,166,454	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 21,731	$ 21,731	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,355	25,355	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,786	26,786	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,613	5,613	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,300	38,300	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	See Schedule 17A	205,948	205,948	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 323,733	$ 323,733	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		584,616	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 584,616	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 323,733	$ 908,349	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 896,633	$ 2,258,105	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,220,366	$ 3,166,454	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Oregon Healthcare Center, Inc.
Provider #: 0037838
12/31/2010

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
Due from State - Interest	11,958	11,958
Short Term Loan Exchange	522,083	522,083
Due To/From Oregon Associates	6,277	-
Due To/From SFO	-	1,191,440
Total Line 9-Other Current Assets (Specify)	540,318	1,725,481

Other Long-Term Assets (Specify)		
RE Investment in SFO	-	53,401
RE Loan Costs	-	103,078
RE Accumulated Amortization-Loan Costs	-	(56,467)
Total Line 22-Other Long-Term Assets (specify)	-	100,012

Other Current Liabilities (Specify)		
Due from State	3,927	3,927
Reimbursement Due	33,753	33,753
Insurance Premiums Payable	464	464
Federal Withholding	(44)	(44)
Accrued Expenses	137,848	137,848
Short Term Loan Exchange	30,000	30,000
Total Line 37-Other Current Liabilities (Specify)	205,948	205,948

See Accountants' Compilation Report

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 836,906	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 836,906	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,726	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 59,727	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)**	$ 896,633	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,028,080	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,028,080	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,286	6
7	Oxygen	(623)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 129,663	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,679	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,679	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,375	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,375	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,165,797	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	765,687	31
32	Health Care	1,238,169	32
33	General Administration	711,815	33
	B. Capital Expense		
34	Ownership	253,384	34
	C. Ancillary Expense		
35	Special Cost Centers	80,076	35
36	Provider Participation Fee	56,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,106,071	40
41	**Income before Income Taxes (line 30 minus line 40)****	59,726	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 59,726	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **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 Oregon Healthcare Center # 0037838 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,600	1,680	$ 44,481	$ 26.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,210	5,352	129,895	24.27	3
4	Licensed Practical Nurses	11,674	12,162	263,300	21.65	4
5	CNAs & Orderlies	44,708	45,937	471,499	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,498	5,811	57,246	9.85	10
11	Social Service Workers	1,789	2,104	26,507	12.60	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,080	40,411	19.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,021	16,731	143,923	8.60	15
16	Dishwashers					16
17	Maintenance Workers	1,768	1,881	28,687	15.25	17
18	Housekeepers	14,546	15,265	139,742	9.15	18
19	Laundry	7,830	8,219	67,164	8.17	19
20	Administrator	2,080	2,200	84,836	38.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,765	7,109	111,914	15.74	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)					33
34	TOTAL (lines 1 - 33)	121,537	126,531	$ 1,609,605 *	$ 12.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 4,609	L1, C3	35
36	Medical Director	Monthly	4,875	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	703	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	6,230	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,417		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dana Payton	Administrator	0	$ 84,836
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,836

B. Administrative - Other

Description	Amount
Home Office	$ 69,600
Management Fees	120,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 189,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Helper Broom LLC	Legal	$ 30,330
Frederick S. Frankel	Legal	225
Williams McCarthy LLP	Legal	1,172
CNA Surety	Notary	30
Midwest Professional Reporting	Legal	856
Honkamp Kruerger & Co	Accounting	494
McGladrey & Pullen LLP	Accounting	18,343
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 51,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,704
Unemployment Compensation Insurance	25,970
FICA Taxes	123,137
Employee Health Insurance	5,276
Employee Meals	3,033
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	3,019
Holiday Expense	224
TOTAL (agree to Schedule V, line 22, col.8)	$ 217,363

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Council on Long Term Care	10,400
Miscellaneous Dues & Permits	222
Miscellaneous Inspections & Licenses	2,115
Allocated from Management Co.	61
Less : COPE Fees & Chamber of Comm	(2,633)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,165

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,779
Allocated from Management Co.	30
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,809

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Health Care Center, Inc.
Provider #: 0037838
12/31/2010

XIX. Support Schedule
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	51,450
Disallow non allowable legal invoices	-
Allocated from Real Estate Entity- Accounting	301
Allocated from Management Company-Accounting	692
Allocated from Management Company-Legal	550
Total Allocated from Management Company	1,242
Allocated from SFO Associates-Accounting	10,977
Total (Agree to Schedule V, Line 19, Column8)	63,970

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
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 Oregon Healthcare Center # 0037838 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. **Illinois Council on Long Term Care-$10,400**

(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. $ **2,358** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **56,940**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **3,033** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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? N/A
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.