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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0051607

Facility Name: Oregon Living & Rehabilitation Center LLC

Address: 811 South 10th Street (Number) Oregon (City) 61061 (Zip Code)

County: Ogle

Telephone Number: (815) 732-7994 **Fax #** (815) 732-3165

HFS ID Number:

Date of Initial License for Current Owners: 9/1/11

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	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 01/01/11 to 12/31/11 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' PREPARATION 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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	365	64	2,373	2,802	8
9	SNF/PED					9
10	ICF	12,417	7,479		19,896	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,782	7,543	2,373	22,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.79%

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 9/1/11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/11 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 2,373

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	200,904	9,757	4,300	214,961		214,961		214,961			1
2	Food Purchase		152,256		152,256		152,256	(282)	151,974			2
3	Housekeeping	150,536	40,333		190,869		190,869	78	190,947			3
4	Laundry	64,414	10,801		75,215		75,215		75,215			4
5	Heat and Other Utilities			98,692	98,692		98,692	991	99,683			5
6	Maintenance	23,755	47,625	7,117	78,497		78,497	390	78,887			6
7	Other (specify):*											7
8	TOTAL General Services	439,609	260,772	110,109	810,490		810,490	1,177	811,667			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,046,770	42,369	1,505	1,090,644		1,090,644	270	1,090,914			10
10a	Therapy			234,544	234,544		234,544		234,544			10a
11	Activities	78,779	6,863		85,642		85,642		85,642			11
12	Social Services	15,938			15,938		15,938		15,938			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,141,487	49,232	239,049	1,429,768		1,429,768	270	1,430,038			16
	C. General Administration											
17	Administrative	86,139		205,727	291,866		291,866	(100,477)	191,389			17
18	Directors Fees											18
19	Professional Services			32,676	32,676		32,676	11,007	43,683			19
20	Dues, Fees, Subscriptions & Promotions			10,753	10,753		10,753	84	10,837			20
21	Clerical & General Office Expenses	106,124		41,049	147,173		147,173	39,509	186,682			21
22	Employee Benefits & Payroll Taxes			230,298	230,298		230,298		230,298			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,598	1,598		1,598	15	1,613			24
25	Other Admin. Staff Transportation			3,919	3,919		3,919	1,546	5,465			25
26	Insurance-Prop.Liab.Malpractice			5,787	5,787		5,787	281	6,068			26
27	Other (specify):* Mgmt Alloc of Benefit							12,302	12,302			27
28	TOTAL General Administration	192,263		531,807	724,070		724,070	(35,733)	688,337			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,773,359	310,004	880,965	2,964,328		2,964,328	(34,286)	2,930,042			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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 Living & Rehabilitation Center LLC #0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			24,467	24,467		24,467	36,433	60,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,717	3,717		3,717	36,715	40,432			32
33	Real Estate Taxes			24,597	24,597		24,597	2,462	27,059			33
34	Rent-Facility & Grounds			300,299	300,299		300,299	(300,299)				34
35	Rent-Equipment & Vehicles							766	766			35
36	Other (specify):*											36
37	TOTAL Ownership			353,080	353,080		353,080	(223,923)	129,157			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,115	8,505	75,620		75,620		75,620			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,897	56,897		56,897		56,897			42
43	Other (specify):* Non-Allow Costs			29,353	29,353		29,353	(29,353)				43
44	TOTAL Special Cost Centers		67,115	94,755	161,870		161,870	(29,353)	132,517			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,773,359	377,119	1,328,800	3,479,278		3,479,278	(287,562)	3,191,716			45

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Refer-ence	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	1,841	30		9
10	Interest and Other Investment Income	21,144	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(192)	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	(4,550)	43		18
19	Entertainment				19
20	Contributions	(1,100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,009)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,448)	43		24
25	Fund Raising, Advertising and Promotional	(1,864)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,906)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	10,350	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 7,266		$	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)	(294,828)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (294,828)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (287,562)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Oregon Living & Rehabilitation Center LLC

ID# 0051607

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (6,569)	43	1
2	X Ray Expense Med A	(3,199)	43	2
3	Trust Fees	(395)	43	3
4	Gain in Investment in Partnership	20,513	43	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				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**	10,350		49

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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%	$ 6,085	$ 6,085	1
2	V	30	Depreciation		Oregon Associates	100.00%	32,028	32,028	2
3	V	32	Interest	21,144	Oregon Associates	100.00%	37,760	16,616	3
4	V	32	Amortization-Mortgage Costs		Oregon Associates	100.00%	3,436	3,436	4
5	V	34	Rent	300,299	Oregon Associates	100.00%		(300,299)	5
6	V	43	Other	20,513	Oregon Associates	100.00%	1,870	(18,643)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 341,956			$ 81,179	$ * (260,777)	14

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.(January-February)	100.00%	$ 18	$ 18	15
16	V	3	Housekeeping		SW Management Co.(January-February)	100.00%	11	11	16
17	V	5	Heat and Other Utilities		SW Management Co.(January-February)	100.00%	134	134	17
18	V	6	Maintenance		SW Management Co.(January-February)	100.00%	53	53	18
19	V	17	Administrative	37,400	SW Management Co.(January-February)	100.00%	13,292	(24,108)	19
20	V	19	Professional Services		SW Management Co.(January-February)	100.00%	128	128	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.(January-February)	100.00%	11	11	21
22	V	21	Clerical & General Office Expense		SW Management Co.(January-February)	100.00%	4,702	4,702	22
23	V	24	Travel and Seminar		SW Management Co.(January-February)	100.00%	2	2	23
24	V	25	Other Admin Staff Transportation		SW Management Co.(January-February)	100.00%	210	210	24
25	V	26	Insurance-Prop. Liab. Malpractice		SW Management Co.(January-February)	100.00%	38	38	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.(January-February)	100.00%	1,667	1,667	26
27	V	30	Depreciation		SW Management Co.(January-February)	100.00%	427	427	27
28	V	32	Interest		SW Management Co.(January-February)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co.(January-February)	100.00%	334	334	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.(January-February)	100.00%	104	104	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			$ 37,400			$ 21,131	$ * (16,269)	39

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 1,577	S & E Medical Supply Co.	100.00%	$ 1,164	$ (413)	15
16	V	10	Medical Supplies		S & E Medical Supply Co.	100.00%	270	270	16
17	V	3	Housekeeping		S & E Medical Supply Co.	100.00%			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			$ 1,577			$ 1,434	$ * (143)	39

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 8,987	$ 8,987	15
16	V	21	Clerical & General Office		SFO Associates	0.00%			16
17	V	32	Interest-Bonds	37,760	SFO Associates	0.00%	33,279	(4,481)	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			$ 37,760			$ 42,266	$ * 4,506	39

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.(March)	100.00%	$ 10	$ 10	15
16	V	3	Housekeeping		SW Management Co.(March)	100.00%	6	6	16
17	V	5	Heat and Other Utilities		SW Management Co.(March)	100.00%	79	79	17
18	V	6	Maintenance		SW Management Co.(March)	100.00%	31	31	18
19	V	17	Administrative	18,700	SW Management Co.(March)	100.00%	7,129	(11,571)	19
20	V	19	Professional Services		SW Management Co.(March)	100.00%	75	75	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.(March)	100.00%	7	7	21
22	V	21	Clerical & General Office Expense		SW Management Co.(March)	100.00%	3,215	3,215	22
23	V	24	Travel and Seminar		SW Management Co.(March)	100.00%	1	1	23
24	V	25	Other Admin Staff Transportation		SW Management Co.(March)	100.00%	123	123	24
25	V	26	Insurance-Prop. Liab. Malpractice		SW Management Co.(March)	100.00%	22	22	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.(March)	100.00%	982	982	26
27	V	30	Depreciation		SW Management Co.(March)	100.00%	213	213	27
28	V	32	Interest		SW Management Co.(March)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co.(March)	100.00%	197	197	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.(March)	100.00%	61	61	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			$ 18,700			$ 12,151	$ * (6,549)	39

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.(April-June)	100.00%	$ 34	$ 34	15
16	V	3	Housekeeping		SW Management Co.(April-June)	100.00%	20	20	16
17	V	5	Heat and Other Utilities		SW Management Co.(April-June)	100.00%	259	259	17
18	V	6	Maintenance		SW Management Co.(April-June)	100.00%	102	102	18
19	V	17	Administrative	56,100	SW Management Co.(April-June)	100.00%	22,838	(33,262)	19
20	V	19	Professional Services		SW Management Co.(April-June)	100.00%	247	247	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.(April-June)	100.00%	22	22	21
22	V	21	Clerical & General Office Expense		SW Management Co.(April-June)	100.00%	10,531	10,531	22
23	V	24	Travel and Seminar		SW Management Co.(April-June)	100.00%	4	4	23
24	V	25	Other Admin Staff Transportation		SW Management Co.(April-June)	100.00%	404	404	24
25	V	26	Insurance-Prop. Liab. Malpractice		SW Management Co.(April-June)	100.00%	74	74	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.(April-June)	100.00%	3,218	3,218	26
27	V	30	Depreciation		SW Management Co.(April-June)	100.00%	640	640	27
28	V	32	Interest		SW Management Co.(April-June)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co.(April-June)	100.00%	644	644	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.(April-June)	100.00%	200	200	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			$ 56,100			$ 39,237	$ * (16,863)	39

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.(July-August)	100.00%	$ 23	$ 23	15
16	V	3	Housekeeping		SW Management Co.(July-August)	100.00%	14	14	16
17	V	5	Heat and Other Utilities		SW Management Co.(July-August)	100.00%	173	173	17
18	V	6	Maintenance		SW Management Co.(July-August)	100.00%	68	68	18
19	V	17	Administrative	37,400	SW Management Co.(July-August)	100.00%	15,224	(22,176)	19
20	V	19	Professional Services		SW Management Co.(July-August)	100.00%	165	165	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.(July-August)	100.00%	15	15	21
22	V	21	Clerical & General Office Expense		SW Management Co.(July-August)	100.00%	7,020	7,020	22
23	V	24	Travel and Seminar		SW Management Co.(July-August)	100.00%	3	3	23
24	V	25	Other Admin Staff Transportation		SW Management Co.(July-August)	100.00%	270	270	24
25	V	26	Insurance-Prop. Liab. Malpractice		SW Management Co.(July-August)	100.00%	49	49	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.(July-August)	100.00%	2,145	2,145	26
27	V	30	Depreciation		SW Management Co.(July-August)	100.00%	427	427	27
28	V	32	Interest		SW Management Co.(July-August)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co.(July-August)	100.00%	429	429	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.(July-August)	100.00%	134	134	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			$ 37,400			$ 26,159	$ * (11,241)	39

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.(September-December)	100.00%	$ 46	$ 46	15
16	V	3	Housekeeping		SW Management Co.(September-December)	100.00%	27	27	16
17	V	5	Heat and Other Utilities		SW Management Co.(September-December)	100.00%	346	346	17
18	V	6	Maintenance		SW Management Co.(September-December)	100.00%	136	136	18
19	V	17	Administrative	16,127	SW Management Co.(September-December)	100.00%	6,767	(9,360)	19
20	V	19	Professional Services		SW Management Co.(September-December)	100.00%	329	329	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.(September-December)	100.00%	29	29	21
22	V	21	Clerical & General Office Expense		SW Management Co.(September-December)	100.00%	14,041	14,041	22
23	V	24	Travel and Seminar		SW Management Co.(September-December)	100.00%	5	5	23
24	V	25	Other Admin Staff Transportation		SW Management Co.(September-December)	100.00%	539	539	24
25	V	26	Insurance-Prop. Liab. Malpractice		SW Management Co.(September-December)	100.00%	98	98	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.(September-December)	100.00%	4,290	4,290	26
27	V	30	Depreciation		SW Management Co.(September-December)	100.00%	857	857	27
28	V	32	Interest		SW Management Co.(September-December)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co.(September-December)	100.00%	858	858	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.(September-December)	100.00%	267	267	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			$ 16,127			$ 28,635	$ * 12,508	39

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Moshe Herman	50%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S.W. Management Co.	Skokie	Bookkeeping	1
2	Stuart Milstein	7.33%						2
3	Ari Milstein	7.33%	Beauvais Manor Healthcare & Rehab	St. Louis, MO	*SFO Associates	Skokie	Finance Company	3
4	Elana Minkove	7.34%	Hillside Manor Healthcare & Rehab	St. Louis, MO				4
5	Amanda Bachrach	4.4%	Rancho Manor Healthcare & Rehab	Florissant, MO	* This entity only relates to Shabbona Healthcare Center,			5
6	Yedida Wolfe	4.4%	Rosewood Health & Rehab Center	Independence, MO	Franklin Grove Living and Rehab, and Oregon Living			6
7	James Wolfe	4.4%			and Rehab			7
8	Neil Wolfe	4.4%						8
9	Richard Wolfe	4.4%			S & E Medical Supply	Skokie	Medical Supplies	9
10	Robin Krystal	4.0%						10
11	David Zuckerman	2.0%			Momentum Healthcar	Skokie	Management Compa	11
12								12
13					Groves Community	Independence, MO	Hospice	13
14					Hospice			14
15								15
16					Forest View Senior	Independence, MO	Independent	16
17					Residences		Living	17
18								18
19					White Oak Living	Independence, MO	Residential Care	19
20					Center			20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Moshe Herman	Owner	Administrative	50.00	162,833	20	50.00	Salary & Fees	$ 40,000	17,3&17,7	1
2											2
3	Sheldon Wolfe	President	Administrative	31.74	See Schedule 7A	3	0.07	Salary	14,500	L17, C7	3
4	Ronnie Klein	Shareholder	Administrative	15.87	See Schedule 7B	10	0.25	Salary & Fees	50,750	17,3&17,7	4
5	Moshe Herman	CFO	Administrative	2.40	See Schedule 7C	3	0.07	Salary	14,500	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 119,750		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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. January-February
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	124,018	12	$ 358	$	6,136	$ 18	1
2	3	Housekeeping	Bed Days Available	124,018	12	213		6,136	11	2
3	5	Heat and Other Utilities	Bed Days Available	124,018	12	2,716		6,136	134	3
4	6	Maintenance	Bed Days Available	124,018	12	1,066		6,136	53	4
5	19	Professional Services	Bed Days Available	124,018	12	2,591		6,136	128	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	124,018	12	229		6,136	11	6
7	21	Clerical & General Office Exp	Bed Days Available	124,018	12	95,042	95,042	6,136	4,702	7
8	24	Travel and Seminar	Bed Days Available	124,018	12	42		6,136	2	8
9	25	Other Admin. Staff Transport.	Bed Days Available	124,018	12	4,236		6,136	210	9
10	26	Insurance-Prop. Liab. & Malp.	Bed Days Available	124,018	12	772		6,136	38	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	124,018	12	33,703		6,136	1,667	11
12	32	Interest	Bed Days Available	124,018	12			6,136	0	12
13	33	Real Estate Taxes	Bed Days Available	124,018	12	6,744		6,136	334	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	124,018	12	2,099		6,136	104	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	3	2,417	17
18	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	3	2,417	18
19	17	Administrative	Avg. Hours Worked	40	3	33,833	33,833	10	8,458	19
20	30	Depreciation	Direct Cost	6,938					427	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 251,310	$ 196,541		$ 21,131	25

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 1,164	1
2	10	Medical Supplies	Direct Cost						270	2
3	3	Housekeeping	Direct Cost							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					$	$		$ 1,434	25

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 29,209	$	2,000,000	$ 8,987	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	108,156		2,000,000	33,279	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					$ 137,365	$		$ 42,266	25

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. March
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	55,304	11	$ 179	$	3,224	$ 10	1
2	3	Housekeeping	Bed Days Available	55,304	11	106		3,224	6	2
3	5	Heat and Other Utilities	Bed Days Available	55,304	11	1,358		3,224	79	3
4	6	Maintenance	Bed Days Available	55,304	11	532		3,224	31	4
5	19	Professional Services	Bed Days Available	55,304	11	1,294		3,224	75	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	55,304	11	115		3,224	7	6
7	21	Clerical & General Office Exp	Bed Days Available	55,304	11	55,153	47,522	3,224	3,215	7
8	24	Travel and Seminar	Bed Days Available	55,304	11	22		3,224	1	8
9	25	Other Admin. Staff Transport.	Bed Days Available	55,304	11	2,118		3,224	123	9
10	26	Insurance-Prop. Liab. & Malp.	Bed Days Available	55,304	11	386		3,224	22	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	55,304	11	16,851		3,224	982	11
12	32	Interest	Bed Days Available	55,304	11			3,224		12
13	33	Real Estate Taxes	Bed Days Available	55,304	11	3,372		3,224	197	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	55,304	11	1,050		3,224	61	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	35	11	16,917	16,917	3	1,450	17
18	17	Administrative	Avg. Hours Worked	35	11	16,917	16,917	3	1,450	18
19	17	Administrative	Avg. Hours Worked	40	3	16,917	16,917	10	4,229	19
20	30	Depreciation	Direct Cost	3,469					213	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 133,287	$ 98,273		$ 12,151	25

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (April-June)
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	148,694	10	$ 537	$	9,464	$ 34	1
2	3	Housekeeping	Bed Days Available	148,694	10	320		9,464	20	2
3	5	Heat and Other Utilities	Bed Days Available	148,694	10	4,074		9,464	259	3
4	6	Maintenance	Bed Days Available	148,694	10	1,599		9,464	102	4
5	19	Professional Services	Bed Days Available	148,694	10	3,886		9,464	247	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	148,694	10	344		9,464	22	6
7	21	Clerical & General Office Exp	Bed Days Available	148,694	10	165,455	142,564	9,464	10,531	7
8	24	Travel and Seminar	Bed Days Available	148,694	10	64		9,464	4	8
9	25	Other Admin. Staff Transport.	Bed Days Available	148,694	10	6,354		9,464	404	9
10	26	Insurance-Prop. Liab. & Malp.	Bed Days Available	148,694	10	1,158		9,464	74	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	148,694	10	50,553		9,464	3,218	11
12	32	Interest	Bed Days Available	148,694	10			9,464		12
13	33	Real Estate Taxes	Bed Days Available	148,694	10	10,116		9,464	644	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	148,694	10	3,149		9,464	200	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	50,750	50,750	3	5,075	17
18	17	Administrative	Avg. Hours Worked	30	10	50,750	50,750	3	5,075	18
19	17	Administrative	Avg. Hours Worked	40	3	50,750	50,750	10	12,688	19
20	30	Depreciation	Direct Cost	10,408					640	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 399,859	$ 294,814		$ 39,237	25

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (July-August)
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	101,308	10	$ 358	$	6,448	$ 23	1
2	3	Housekeeping	Bed Days Available	101,308	10	213		6,448	14	2
3	5	Heat and Other Utilities	Bed Days Available	101,308	10	2,716		6,448	173	3
4	6	Maintenance	Bed Days Available	101,308	10	1,066		6,448	68	4
5	19	Professional Services	Bed Days Available	101,308	10	2,591		6,448	165	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	101,308	10	229		6,448	15	6
7	21	Clerical & General Office Exp	Bed Days Available	101,308	10	110,303	95,042	6,448	7,020	7
8	24	Travel and Seminar	Bed Days Available	101,308	10	42		6,448	3	8
9	25	Other Admin. Staff Transport.	Bed Days Available	101,308	10	4,236		6,448	270	9
10	26	Insurance-Prop. Liab. & Malp.	Bed Days Available	101,308	10	772		6,448	49	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	101,308	10	33,703		6,448	2,145	11
12	32	Interest	Bed Days Available	101,308	10			6,448		12
13	33	Real Estate Taxes	Bed Days Available	101,308	10	6,744		6,448	429	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	101,308	10	2,099		6,448	134	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	17
18	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	18
19	17	Administrative	Avg. Hours Worked	40	3	33,833	33,833	10	8,458	19
20	30	Depreciation	Direct Cost	6,938					427	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 266,571	$ 196,541		$ 26,159	25

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (September-December)
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	199,348	10	$ 716	$	12,688	$ 46	1
2	3	Housekeeping	Bed Days Available	199,348	10	426		12,688	27	2
3	5	Heat and Other Utilities	Bed Days Available	199,348	10	5,432		12,688	346	3
4	6	Maintenance	Bed Days Available	199,348	10	2,131		12,688	136	4
5	19	Professional Services	Bed Days Available	199,348	10	5,181		12,688	329	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	199,348	10	458		12,688	29	6
7	21	Clerical & General Office Exp	Bed Days Available	199,348	10	220,606	30,521	12,688	14,041	7
8	24	Travel and Seminar	Bed Days Available	199,348	10	86		12,688	5	8
9	25	Other Admin. Staff Transport.	Bed Days Available	199,348	10	8,472		12,688	539	9
10	26	Insurance-Prop. Liab. & Malp.	Bed Days Available	199,348	10	1,543		12,688	98	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	199,348	10	67,405		12,688	4,290	11
12	32	Interest	Bed Days Available	199,348	10			12,688		12
13	33	Real Estate Taxes	Bed Days Available	199,348	10	13,488		12,688	858	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	199,348	10	4,198		12,688	267	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	67,667	67,667	3	6,767	17
18										18
19	17	Administrative	Avg. Hours Worked	15	1	67,667	67,667			19
20	30	Depreciation	Direct Cost	13,877					857	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 465,476	$ 165,855		$ 28,635	25

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 461,539	8/15/17	Variable	$ 34,179	1
2	(Payable to SFO Assoc)				of $92,408							2
3												3
4												4
5												5
	Working Capital											
6	Sheldon Wolfe		X	Working Capital		9/1/11	250,000	250,000	8/31/14	1.6900	1,408	6
7	Albert Milstein		X	Working Capital		9/1/11	250,000	250,000	8/31/14	1.6900	1,409	7
8												8
9	TOTAL Facility Related						$ 2,500,000	$ 961,539			$ 36,996	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			3,436	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,436	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 961,539			$ 40,432	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.)**

**** 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 Living & Rehabilitation Center LLC **#** 0051607 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)	**2010**	$ 24,597	2
3. Under or (over) accrual (line 2 minus line 1).		$ 24,597	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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
	Allocated from Management Co.	2,462	
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.		$ 27,059	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	32,862	8
2007	33,979	9
2008	36,033	10
2009	37,217	11
2010	24,597	12

This facility does not accrue real estate taxes since it is part of the lease agreement.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oregon Living & Rehabilitation Center LLC COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0051607

CONTACT PERSON REGARDING THIS REPORT Moshe Herman

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 2010 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 2010.

	(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	$ 36,646.90	$ 24,597.00
2.	10-28-412-049-0000	SW Management Allocation	$ 33,410.00	$ 2,003.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,056.90	$ 26,600.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [ ] (b) Rent from a Related Organization. [X] (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 [ ] (b) Rent equipment from a Related Organization. [X] (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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 500,236	4
5											5
6	SW Management Allocation		1995		26,661		39	762	762	12,687	6
7											7
8											8
	Improvement Type**										
9	Various			1992	6,160		20			6,160	9
10	Various			1993	26,517	200	20	1,295	1,095	24,767	10
11	Various			1994	5,324		20	266	266	4,909	11
12	Various			1995	3,498		20	175	175	2,901	12
13	Various			1996	2,042	33	20	102	69	1,564	13
14	Various			1997	2,880	85	20	144	59	2,100	14
15	Various			1998	65,055	583	20	3,253	2,670	46,068	15
16	Various			1999	36,058	463	20	1,803	1,340	23,063	16
17											17
18	Model 10Kpa Code A/R			2001	1,189		20	59	59	619	18
19	Generator Repair			2001	1,010		20	51	51	515	19
20	Motor			2001	783		20	39	39	417	20
21	Glass Thermo Unit			2001	868		20	43	43	455	21
22	Install Board			2001	816		20	41	41	423	22
23	Gas Controller			2001	739		20	37	37	379	23
24	Clutch & Output Brd			2001	1,138		20	57	57	583	24
25	Vinyl Flooring			2001	912		20	46	46	499	25
26											26
27	Air Conditioners			2002	1,470		20	74	74	883	27
28	Air Conditioners			2002	1,366		20	68	68	762	28
29	Wall-Replaced			2002	5,000	57	20	250	193	2,396	29
30											30
31	Roof Exhaust Fan			2003	3,128		10	313	313	2,659	31
32	Condensor walk - in Freezer			2003	3,193		7			3,193	32
33	Radiator			2003	3,473		10	347	347	2,865	33
34	Hot Water Repair			2003	1,610		20	81	81	672	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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 349	20	$ 793	$ 444	$ 5,945	37
38	Counter tops	2004	4,668		20	233	233	1,750	38
39	Nurses Station	2004	1,290		20	65	65	485	39
40	Basin	2004	7,500	120	20	375	255	2,813	40
41									41
42	Flooring	2005	3,703	84	20	185	101	1,203	42
43	Fire Alarm System	2005	1,932	44	20	97	53	629	43
44	Wanderguard	2005	1,632	37	10	163	126	1,060	44
45	Air Conditioners	2005	1,008		10	101	101	656	45
46									46
47	Vertical Rods with Panic Bars	2006	3,036	95	20	152	57	835	47
48	Smoke Stops-Attic	2006	1,140		20	57	57	314	48
49	Sidewalks	2006	5,106	159	20	255	96	1,404	49
50	Air Conditioners	2006	5,430	311	20	272	(40)	1,494	50
51	Sprinkler System	2006	62,467	1,454	20	3,123	1,669	17,178	51
52	Damper Switches - Sprinkler Systems	2006	1,505		20	75	75	414	52
53									53
54	Walk-in Freezer Condensing Unit	2007	6,016	136	20	301	165	1,352	54
55	Remodel Bathrooms	2009	14,939	339	20	747	408	1,867	55
56	Glue down carpet	2009	3,287	75	20	164	89	411	56
57									57
58	Rooftop A/C Unit	2010	13,256	301	20	663	362	994	58
59	Patio & Sidewalk	2010	3,575		20	179	179	268	59
60									60
61	Flooring	2011	18,785		20	470	470	470	61
62	Kitchen Flooring	2011	4,139		20	103	103	103	62
63	12 Ton Roof Top HVAC unit	2011	16,250		20	406	406	406	63
64	Sidewalk & Driveway	2011	5,550		20	139	139	139	64
65	Parking lot seal coating	2011	3,850	3,850	20	32	(3,818)	32	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,415,684	$ 8,775		$ 43,676	$ 34,901	$ 683,994	70

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,415,684	$ 8,775		$ 43,676	$ 34,901	$ 683,994	1
2	SW Management allocation - Leasehold Improvements	1995	2,983		20	149	149	2,687	2
3	SW Management allocation - Leasehold Improvements	1996	497		20	25	25	386	3
4	SW Management allocation - Leasehold Improvements	1997	576		20	29	29	488	4
5	SW Management allocation - Leasehold Improvements	1998	493		20	24	24	338	5
6	SW Management allocation - Leasehold Improvements	1999	1,367		20	69	69	826	6
7	SW Management allocation - Leasehold Improvements	2005	2,829		20	141	141	919	7
8	SW Management allocation - Leasehold Improvements	2007	1,601		20	80	80	360	8
9	SW Management allocation - Leasehold Improvements	2009	3,344		20	167	167	418	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)		$ 1,429,374	$ 8,775		$ 44,360	$ 35,585	$ 690,416	34

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 69,167	$ 627	$ 6,920	$ 6,293	10	$ 27,261	71
72	Current Year Purchases	23,008	14,257	675	(13,582)		675	72
73	Fully Depreciated Assets	356,962					356,962	73
74	Mgmt. Company	8,419		171	171		6,682	74
75	TOTALS	$ 457,556	$ 14,884	$ 7,766	$ (7,118)		$ 391,580	75

D. Vehicle Costs. (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	$ 3,864	76
77	Resident Care	E-350 Van	2003	26,099				7	26,099	77
78	Resident Care	2008 Chevy Van & lift	2007	36,812	808	7,362	6,554	5	33,130	78
79	Allocated from Management	Infiniti	2010	4,737		948	948		1,421	79
80	TOTALS			$ 72,283	$ 808	$ 8,774	$ 7,966		$ 64,514	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)	$ 2,009,213	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,467	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 60,900	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 36,433	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,146,510	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.

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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.		$	$ 766	17
18					18
19					19
20					20
21	TOTAL		$	$ 766	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.

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	818	$ 91,629	$	818	$ 91,629	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		806	19,352		806	19,352	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,086	112,983		1,086	112,983	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				67,115		67,115	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			$	2,710	$ 223,964	$ 67,115	2,710	$ 291,079	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.

STATE OF ILLINOIS

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 109,030	$ 109,030	1
2	Cash-Patient Deposits	12,878	12,878	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	723,273	723,273	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,154	3,154	6
7	Other Prepaid Expenses		331	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	163,735	1,514,550	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,012,070	$ 2,363,216	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		1,035,541	14
15	Leasehold Improvements, at Historical Cost	3,850	393,833	15
16	Equipment, at Historical Cost	14,257	529,839	16
17	Accumulated Depreciation (book methods)	(18,107)	(1,146,510)	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	6,475	123,564	22
23	Other(specify): Prior Owner Balance	(22,554)	(22,554)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (16,079)	$ 963,713	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 995,991	$ 3,326,929	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,311	$ 41,311	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,680	19,680	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,929	53,929	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,738	10,738	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,817	2,817	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Option Deposits		163,000	36
37	See Schedule 17A	239,478	239,478	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 367,953	$ 530,953	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	500,000	961,539	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)**	$ 500,000	$ 961,539	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 867,953	$ 1,492,492	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 128,038	$ 1,834,437	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 995,991	$ 3,326,929	48

*(See instructions.)

Oregon Living & Rehabilitation Center LLC
0051607
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Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
Due to/from SFP Associates	-	1,223,924
Short Term Loan Exchange	735	735
Due to Oregon Health Care	-	126,891
Due To/From FOM Property - Dep OP	163,000	163,000
Total Line 9-Other Current Assets (Specify)	163,735	1,514,550

Other Long-Term Assets (Specify)		
RE Investment in SFO	-	73,914
RE Loan Costs	-	103,078
RE Accumulated Amortization-Loan Costs	-	(59,903)
Security Deposits	6,475	6,475
Total Line 22-Other Long-Term Assets (specify)	6,475	123,564

Other Current Liabilities (Specify)		
Insurance Premiums Payable	186	186
Accrued Expenses	88,592	88,592
Short Term Loan Exchange	150,700	150,700
Total Line 37-Other Current Liabilities (Specify)	239,478	239,478

See Accountants' Preparation Report

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC **#** 0051607 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 95,000	1
2	Restatements (describe):		2
3	**Prior Owner Adjustment**	(324,654)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (229,654)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	357,692	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 357,692	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)**	$ 128,038	24 *

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 3,732,249	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,732,249	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,892	6
7	Oxygen	1,718	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 90,610	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***	11,768	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,768	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	2,343	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,343	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,836,970	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	810,490	31
32	Health Care	1,429,768	32
33	General Administration	724,070	33
	B. Capital Expense		
34	Ownership	353,080	34
	C. Ancillary Expense		
35	Special Cost Centers	104,973	35
36	Provider Participation Fee	56,897	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,479,278	40
41	**Income before Income Taxes (line 30 minus line 40)****	357,692	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 357,692	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.**

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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2,080	2,080	$ 55,278	$ 26.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,847	7,103	175,920	24.77	3
4	Licensed Practical Nurses	12,205	12,809	287,275	22.43	4
5	CNAs & Orderlies	48,402	49,421	528,297	10.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,498	7,749	78,779	10.17	10
11	Social Service Workers	1,853	1,875	15,938	8.50	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,080	41,925	20.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,723	17,300	158,979	9.19	15
16	Dishwashers					16
17	Maintenance Workers	1,635	1,694	23,755	14.02	17
18	Housekeepers	15,114	15,915	150,536	9.46	18
19	Laundry	6,998	7,440	64,414	8.66	19
20	Administrator	2,080	2,160	86,139	39.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,928	6,290	106,124	16.87	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)	129,387	133,916	$ 1,773,359 *	$ 13.24	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	$ 4,300	L1, C3	35
36	Medical Director	Monthly	3,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,505	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	10,580	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)		$ 19,385		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

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dana Payton	Administrator	0	$ 86,139
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,139

B. Administrative - Other

Description	Amount
Moshe Herman / Momentum Healthcare, LLC	$ 40,000
SW Management Fees (Eliminated on Schedule V, Column 7)	80,000
Home Office (Eliminated on Schedule V, Column 7)	85,727
TOTAL (agree to Schedule V, line 17, col. 3)	$ 205,727
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Helper Broom LLC	Legal	$ 5,586
Smith Hahn Morrow & Floski PC	Legal	138
Williams McCarthy LLP	Legal	468
Stephen N Sher PC	Legal	5,009
McGladrey & Pullen LLP	Accounting	21,475
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 32,676

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,630
Unemployment Compensation Insurance	49,827
FICA Taxes	134,619
Employee Health Insurance	(1,385)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	13,342
Holiday Expense	1,065
Life Insurance	1,200
TOTAL (agree to Schedule V, line 22, col.8)	$ 230,298

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 127)	1,523
Patient Background Checks	
Illinois Council on Long Term Care	2,327
Miscellaneous Dues & Permits	222
Miscellaneous Inspections & Licenses	6,681
Allocated from Management Co.	84
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,837

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,598
Allocated from Management Co.	15
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,613

* Attach copy of IMRF notifications

**See instructions.

Oregon Living & Rehabilitation Center LLC
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XIX. Support Schedule
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	32,676
Disallow non allowable legal invoices	(5,009)
Allocated from Real Estate Entity- Accounting	6,085
Allocated from Management Company-Accounting	826
Allocated from Management Company-Legal	118
Total Allocated from Management Company	944
Allocated from SFO Associates-Accounting	8,987
Total (Agree to Schedule V, Line 19, Column8)	43,683

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC # 0051607 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oregon Living & Rehabilitation Center LLC **#** 0051607 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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-$ 2327**

(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. $ **5,406** 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 **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Oregon Healthcare Center, Inc. / #0037838 / September 1, 2011

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **56,897**
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. $ **0** 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.