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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/12 to 12/31/12 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) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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: 01/01/12 Ending: 12/31/12

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	38,064	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	38,064	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	371	285	2,231	2,887	8
9	SNF/PED					9
10	ICF	14,054	8,775		22,829	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,425	9,060	2,231	25,716	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.56%

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 2,231

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

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

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	207,353	13,995	4,487	225,835		225,835		225,835			1
2	Food Purchase		170,012		170,012		170,012	1,092	171,104			2
3	Housekeeping	137,369	39,280		176,649		176,649	43	176,692			3
4	Laundry	66,415	7,847		74,262		74,262		74,262			4
5	Heat and Other Utilities			92,125	92,125		92,125	1,021	93,146			5
6	Maintenance	47,346	59,776	7,102	114,224		114,224	4,204	118,428			6
7	Other (specify):*											7
8	**TOTAL General Services**	458,483	290,910	103,714	853,107		853,107	6,360	859,467			8
	B. Health Care and Programs											
9	Medical Director			8,350	8,350		8,350		8,350			9
10	Nursing and Medical Records	1,135,416	33,960	8,486	1,177,862		1,177,862	(1,190)	1,176,672			10
10a	Therapy											10a
11	Activities	112,560	5,045		117,605		117,605		117,605			11
12	Social Services	17,070			17,070		17,070		17,070			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,265,046	39,005	16,836	1,320,887		1,320,887	(1,190)	1,319,697			16
	C. General Administration											
17	Administrative	87,711		184,509	272,220		272,220	(80,914)	191,306			17
18	Directors Fees											18
19	Professional Services			23,873	23,873		23,873	6,259	30,132			19
20	Dues, Fees, Subscriptions & Promotions			14,515	14,515		14,515	(234)	14,281			20
21	Clerical & General Office Expenses	117,531		38,360	155,891		155,891	35,543	191,434			21
22	Employee Benefits & Payroll Taxes			268,858	268,858		268,858		268,858			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,585	3,585		3,585	70	3,655			24
25	Other Admin. Staff Transportation			14,499	14,499		14,499	1,702	16,201			25
26	Insurance-Prop.Liab.Malpractice			11,188	11,188		11,188	312	11,500			26
27	Other (specify):* Mgmt Alloc of Benefi							12,400	12,400			27
28	**TOTAL General Administration**	205,242		559,387	764,629		764,629	(24,862)	739,767			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,928,771	329,915	679,937	2,938,623		2,938,623	(19,692)	2,918,931			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: 01/01/12 Ending: 12/31/12

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			17,886	17,886		17,886	43,660	61,546			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,625	13,625		13,625	(9,599)	4,026			32
33	Real Estate Taxes							52,300	52,300			33
34	Rent-Facility & Grounds			531,530	531,530		531,530	(531,530)				34
35	Rent-Equipment & Vehicles			1,452	1,452		1,452	736	2,188			35
36	Other (specify):*											36
37	**TOTAL Ownership**			564,493	564,493		564,493	(444,433)	120,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,651	257,598	320,249		320,249		320,249			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			199,620	199,620		199,620		199,620			42
43	Other (specify):* Non-Allowable Cos			35,854	35,854		35,854	(35,854)				43
44	**TOTAL Special Cost Centers**		62,651	493,072	555,723		555,723	(35,854)	519,869			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,928,771	392,566	1,737,502	4,058,839		4,058,839	(499,979)	3,558,860			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: 01/01/12 Ending: 12/31/12

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	5,145	30		9
10	Interest and Other Investment Income	(8,689)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(139)	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	(122)	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	(1,005)	43		24
25	Fund Raising, Advertising and Promotional	(2,256)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,000)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(54,793)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,859)		$	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)	(435,120)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (435,120)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (499,979)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (3,601)	43	1
2	X Ray Expense Med A	(1,814)	43	2
3	Gain in Investment in Partnership	(2,575)	43	3
4	Chamber of Commerce	(397)	20	4
5	Managed Care Costs	(26,917)	43	5
6	Non-Allowable Management Fees	(23,349)	17	6
7	Expense Improvements under $2,500 to R/M	3,860	6	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**	(54,793)		49

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

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%	$ 2,110	$ 2,110	1
2	V	30	Depreciation		Oregon Associates	100.00%	36,123	36,123	2
3	V	32	Interest	12,095	Oregon Associates	100.00%	12,036	(59)	3
4	V	32	Amortization-Mortgage Costs		Oregon Associates	100.00%	3,436	3,436	4
5	V	33	Real Estate Taxes		Oregon Associates	100.00%	50,365	50,365	5
6	V	34	Rent	531,530	Oregon Associates	100.00%		(531,530)	6
7	V	43	Other		Oregon Associates	100.00%	5,575	5,575	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 543,625			$ 109,645	$ * (433,980)	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: 01/01/12 Ending: 12/31/12

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 Financial Services Company	100.00%	$ 212	$ 212	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	43	43	16
17	V	5	Utilities		SW Financial Services Company	100.00%	1,021	1,021	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	344	344	18
19	V	17	Administrative	64,509	SW Financial Services Company	100.00%	6,944	(57,565)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	827	827	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	163	163	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	35,543	35,543	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	70	70	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	1,702	1,702	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	312	312	25
26	V	27	Other		SW Financial Services Company	100.00%	12,400	12,400	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	2,392	2,392	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	1,935	1,935	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	736	736	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			$ 64,509			$ 64,644	$ * 135	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: 01/01/12 Ending: 12/31/12

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	$ 4,922	S & E Medical Supply Co.	100.00%	$ 5,802	$ 880	15
16	V	10	Medical Supplies	2,040	S & E Medical Supply Co.	100.00%	850	(1,190)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,962			$ 6,652	$ * (310)	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: 01/01/12 Ending: 12/31/12

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%	$ 3,322	$ 3,322	15
16	V	32	Interest-Bonds	12,036	SFO Associates	0.00%	7,749	(4,287)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,036			$ 11,071	$ * (965)	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: 01/01/12 Ending: 12/31/12

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%	Cahokia Nursing and Rehab	Cahokia	Praire Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	7.33%	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	7.33%	Praire Crossing Living & Rehab Center, LLC	Shabbona	SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	7.34%			Services Co.		Management Comp.	4
5	Amanda Bachrach	4.4%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Yedida Wolfe	4.4%	Oregon Living & Rehabilitation, LLC	Oregon	* SFO Associates	Skokie	Finance Company	6
7	James Wolfe	4.4%						7
8	Neil Wolfe	4.4%			* This entity only relates to Praire Crossing Living & Rehab,			8
9	Richard Wolfe	4.4%			Franklin Grove Living & Rehab, and Oregon Living & Rehab			9
10	Robin Krystal	4.0%	Beauvais Manor Healthcare and Rehab	St. Louis, MO				10
11	David Zuckerman	2.0%	Hillside Manor Healthcare and Rehab	St. Louis, MO	Groves Community	Independence, MO	Hospice	11
12			Rancho Manor Healthcare and Rehab	Florissant, MO	Hospice			12
13			Rosewood Health & Rehab	Independence, MO	Forest View Senior	Independence, MO	Independent	13
14			Seasons Care Center	Kansas City, MO	Residences		Living	14
15					White Oak Living	Independence, MO	Residential	15
16					Center		Care	16
17								17
18					Seasons Day Services	Kansas City, MO	Adult Day Care	18
19					Program LLC			19
20								20
21					Cahokia Building LLC	Cahokia	Real Estae	21
22					Caseyville Property LL	Caseyville	Real Estate	22
23					Shabbona Building	Shabbona	Real Estate	23
24					Associates LLC			24
25								25
26					Franklin Grove	Franklin Grove	Real Estate	26
27					Associates			27
28					Oregon Associates	Oregon	Real Estate	28
29								29
30								30

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

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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	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

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

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	112,449	20	50.00	Salary & Fees	$ 96,651	17,3 & 17,7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 96,651		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: 01/01/12 Ending: 12/31/12

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 Financial Services Company
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	609,314	12	$ 3,388	$	38,064	$ 212	1
2	3	Housekeeping	Bed Days Available	609,314	12	696		38,064	43	2
3	5	Utilities	Bed Days Available	609,314	12	16,350		38,064	1,021	3
4	6	Maintenance	Bed Days Available	609,314	12	5,506		38,064	344	4
5	19	Professional Services-Legal	Bed Days Available	609,314	12	1,572		38,064	98	5
6	19	Professional Services-Other	Bed Days Available	609,314	12	11,672		38,064	729	6
7	20	Dues, Fees, Subs. & Promotions	Bed Days Available	609,314	12	2,612		38,064	163	7
8	21	Clerical & General Office Expens	Bed Days Available	609,314	12	495,892	495,892	38,064	30,979	8
9	21	Clerical & General Office Expens	Bed Days Available	609,314	12	73,053		38,064	4,564	9
10	24	Travel & Seminar	Bed Days Available	609,314	12	1,122		38,064	70	10
11	25	Other Admin. Staff Transportion	Bed Days Available	609,314	12	27,251		38,064	1,702	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	609,314	12	4,999		38,064	312	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	609,314	12	198,498		38,064	12,400	13
14	33	Real Estate Taxes	Bed Days Available	609,314	12	30,980		38,064	1,935	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	609,314	12	11,776		38,064	736	15
16										16
17	17	Administrative	Avg. Hours Worked	45	11	209,100	209,100	1	4,647	17
18	17	Administrative	Avg. Hours Worked	45	11	103,345	103,345	1	2,297	18
19	30	Depreciation	Direct Cost	38,287					2,392	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,197,812	$ 808,337		$ 64,644	25

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

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			$	$		$ 5,802	1
2	10	Medical Supplies	Direct Cost						850	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,652	25

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

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	$ 10,796	$	2,000,000	$ 3,322	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	25,185		2,000,000	7,749	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,981	$		$ 11,071	25

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

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Oregon Associates	X		Bonds	Annual	7/1/04	$ 2,000,000	$	8/15/17	Variable	$ 19,785	1
2	(Loan Payable-SFO Assoc)											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	0.0095	2,388	6
7	Albert Milstein	X		Working Capital		9/1/11	250,000	250,000	8/31/14	0.0095	2,389	7
8	MB Financial Bank		X	Working Capital	Interest Only	2/10/12	750,000	300,000	2/10/13	0.0425	8,848	8
9	TOTAL Facility Related						$ 3,250,000	$ 800,000			$ 33,410	9
	B. Non-Facility Related*											
10								Amortization of loan cost			3,436	10
11								Interest Income Offset			(32,820)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (29,384)	14
15	TOTALS (line 9+line14)						$ 3,250,000	$ 800,000			$ 4,026	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: 01/01/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)	2011	$ 36,944	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,944	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,050	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Allocated from Management Co.	1,935	
	Under Accrual from PY	(24,629)	
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.		$ 52,300	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	33,979	8
	2008	36,033	9
	2009	37,217	10
	2010	24,597	11
	2011	36,944	12

2012 Tax Accrual = 36,944 * 1.03 = 38,052. Use $38,050

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 36,943.94	$ 36,943.94
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 33,685.36	$ 1,935.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,629.30	$ 38,878.94

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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 [ ] (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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

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	$ 525,458	4
5											5
6	SW Management Allocation		1995		24,868		39	711	711	12,544	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	26,062	10
11	Various			1994	5,324		20	266	266	5,175	11
12	Various			1995	3,498		20	175	175	3,076	12
13	Various			1996	2,042	33	20	102	69	1,666	13
14	Various			1997	2,880	85	20	144	59	2,244	14
15	Various			1998	65,055	583	20	3,253	2,670	49,320	15
16	Various			1999	36,058	463	20	1,803	1,340	24,866	16
17											17
18	Model 10Kpa Code A/R			2001	1,189		20	59	59	678	18
19	Generator Repair			2001	1,010		20	51	51	566	19
20	Motor			2001	783		20	39	39	456	20
21	Glass Thermo Unit			2001	868		20	43	43	499	21
22	Install Board			2001	816		20	41	41	464	22
23	Gas Controller			2001	739		20	37	37	416	23
24	Clutch & Output Brd			2001	1,138		20	57	57	640	24
25	Vinyl Flooring			2001	912		20	46	46	544	25
26											26
27	Air Conditioners			2002	1,470		20	74	74	957	27
28	Air Conditioners			2002	1,366		20	68	68	830	28
29	Wall-Replaced			2002	5,000	57	20	250	193	2,646	29
30											30
31	Roof Exhaust Fan			2003	3,128		10	313	313	2,972	31
32	Condensor walk - in Freezer			2003	3,193		7			3,193	32
33	Radiator			2003	3,473		10	347	347	3,212	33
34	Hot Water Repair			2003	1,610		20	81	81	753	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: 01/01/12 Ending: 12/31/12

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	Nurses Station	2004	$ 15,850	$ 349	20	$ 793	$ 444	$ 6,737	37
38	Counter tops	2004	4,668		20	233	233	1,983	38
39	Nurses Station	2004	1,290		20	65	65	549	39
40	Basin	2004	7,500	120	20	375	255	3,188	40
41									41
42	Flooring	2005	3,703	84	20	185	101	1,388	42
43	Fire Alarm System	2005	1,932	44	20	97	53	725	43
44	Wanderguard	2005	1,632	37	10	163	126	1,224	44
45	Air Conditioners	2005	1,008		10	101	101	756	45
46									46
47	Vertical Rods with Panic Bars	2006	3,036	95	20	152	57	987	47
48	Smoke Stops-Attic	2006	1,140		20	57	57	371	48
49	Sidewalks	2006	5,106	159	20	255	96	1,659	49
50	Air Conditioners	2006	5,430	311	20	272	(40)	1,766	50
51	Sprinkler System	2006	62,467	1,454	20	3,123	1,669	20,301	51
52	Damper Switches - Sprinkler Systems	2006	1,505		20	75	75	489	52
53									53
54	Walk-in Freezer Condensing Unit	2007	6,016	136	20	301	165	1,653	54
55	Remodel Bathrooms	2009	14,939	339	20	747	408	2,614	55
56	Glue down carpet	2009	3,287	75	20	164	89	575	56
57									57
58	Rooftop A/C Unit	2010	13,256	301	20	663	362	1,657	58
59	Patio & Sidewalk	2010	3,575		20	179	179	447	59
60									60
61	Flooring	2011	18,785		20	939	939	1,409	61
62	Kitchen Flooring	2011	4,139		20	207	207	310	62
63	12 Ton Roof Top HVAC unit	2011	16,250		20	813	813	1,219	63
64	Sidewalk & Driveway	2011	5,550		20	278	278	417	64
65	Parking lot seal coating	2011	3,850		20	193	193	225	65
66									66
67	Dining Room Flooring	2012	12,629		20	316	316	316	67
68	Install Columns and Rails - Front Porch	2012	7,200		20	180	180	180	68
69	Parking Lot Lights	2012	10,223		20	256	256	256	69
70	TOTAL (lines 4 thru 69)		$ 1,443,943	$ 4,925		$ 45,655	$ 40,730	$ 728,795	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: 01/01/12 Ending: 12/31/12

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		$ 1,443,943	$ 4,925		$ 45,655	$ 40,730	$ 728,795	1
2	Allocated from SW Financial Services Co. - Leasehold Improvemer	1995	2,783		20	139	139	2,646	2
3	Allocated from SW Financial Services Co. - Leasehold Improvemer	1996	463		20	23	23	384	3
4	Allocated from SW Financial Services Co. - Leasehold Improvemer	1997	537		20	27	27	483	4
5	Allocated from SW Financial Services Co. - Leasehold Improvemer	1998	459		20	23	23	339	5
6	Allocated from SW Financial Services Co. - Leasehold Improvemer	1999	1,275		20	64	64	834	6
7	Allocated from SW Financial Services Co. - Leasehold Improvemer	2005	2,639		20	132	132	989	7
8	Allocated from SW Financial Services Co. - Leasehold Improvemer	2007	1,494		20	75	75	411	8
9	Allocated from SW Financial Services Co. - Leasehold Improvemer	2009	3,119		20	155	155	546	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)		$ 1,456,712	$ 4,925		$ 46,293	$ 41,368	$ 735,427	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: 01/01/12 Ending: 12/31/12

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	$ 92,956	$ 12,153	$ 9,050	$ (3,103)	10	$ 37,767	71
72	Current Year Purchases	20,288		1,014	1,014	10	1,014	72
73	Fully Depreciated Assets	347,748					347,748	73
74	Mgmt. Co.	7,852		159	159	10	6,392	74
75	TOTALS	$ 468,844	$ 12,153	$ 10,223	$ (1,930)		$ 392,921	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	$ 4,328	76
77	Resident Care	2008 Chevy Van & lift	2007	36,812	808	3,682	2,874	5	36,812	77
78										78
79	Allocated from Management	2010 Infiniti	2010	4,418		884	884	5	2,209	79
80	TOTALS			$ 45,865	$ 808	$ 5,030	$ 4,222		$ 43,349	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)	$ 2,021,421	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,886	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,546	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,660	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,171,697	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: 01/01/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 1,452 Description: Nursing Equipment
    (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.		$	$ 736	17
18					18
19					19
20					20
21	TOTAL		$	$ 736	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: 01/01/12 Ending: 12/31/12

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	1,506	$ 108,400	$	1,506	$ 108,400	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		594	28,492		594	28,492	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		1,882	120,431		1,882	120,431	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				62,651		62,651	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			$	3,982	$ 257,323	$ 62,651	3,982	$ 319,974	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.

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 50,326	$ 50,326	1
2	Cash-Patient Deposits	6,729	6,729	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,549,011	1,549,011	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,606	1,606	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	194,238	1,518,213	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,801,910	$ 3,125,885	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		1,033,748	14
15	Leasehold Improvements, at Historical Cost	37,762	422,964	15
16	Equipment, at Historical Cost	34,545	514,709	16
17	Accumulated Depreciation (book methods)	(35,993)	(1,171,697)	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 (sp See Schedule 17A	6,475	48,977	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 42,789	$ 898,701	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,844,699	$ 4,024,586	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 120,684	$ 120,684	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,996	16,996	28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	49,718	49,718	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,391	13,391	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,050	32
33	Accrued Interest Payable	7,594	7,594	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	235,830	398,830	36
37	Due to/fr. Oregon Health / OA	11,183	258,277	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 755,396	$ 1,203,540	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	500,000	500,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	40,292	40,292	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 540,292	$ 540,292	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,295,688	$ 1,743,832	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 549,011	$ 2,280,754	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,844,699	$ 4,024,586	48

*(See instructions.)

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Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
Due from State - Interest	12,938	12,938
Due to/from FOM Property - Dep OP	181,300	181,300
Due to/from SFP Associates	-	1,323,975
Total Line 9-Other Current Assets (Specify)	194,238	1,518,213

Other Long-Term Assets (Specify)		
RE Investment in SFO	-	2,763
RE Loan Costs	-	103,078
RE Accumulated Amortization-Loan Costs	-	(63,339)
Security Deposits	6,475	6,475
Total Line 22-Other Long-Term Assets (specify)	6,475	48,977

Other Current Liabilities (Specify)		
Insurance Premiums Payable	5,814	5,814
Accrued Expenses	208,159	208,159
Option Deposits	-	163,000
Short Term Loan Exchange	700	700
Due to Public Aid	21,157	21,157

Total Line 36-Other Current Liabilities (Specify)	235,830	398,830

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 128,038	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 128,038	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	420,974	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)**	$ 420,973	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)**	$ 549,011	24 *

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

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

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,334,854	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,334,854	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,469	6
7	Oxygen	3,847	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 126,316	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	15	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,035	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,035	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Medicaid Income Adjustments**	5,543	28
28a	**Van Charge**	50	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,593	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,479,813	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	853,107	31
32	Health Care	1,320,887	32
33	General Administration	764,629	33
	B. Capital Expense		
34	Ownership	564,493	34
	C. Ancillary Expense		
35	Special Cost Centers	356,103	35
36	Provider Participation Fee	199,620	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,058,839	40
41	**Income before Income Taxes (line 30 minus line 40)****	420,974	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 420,974	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,414,959	44
45	Private Pay - Net Inpatient Revenue	1,010,975	45
46	Medicare - Net Inpatient Revenue	904,057	46
47	Other-(specify) **Hospice**	4,863	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,334,854	49

* **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.**

*** **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.**

^ - This entity is a cash basis taxpayer.

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

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	2,040	2,080	$ 57,249	$ 27.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,402	9,867	242,478	24.57	3
4	Licensed Practical Nurses	10,973	11,552	257,460	22.29	4
5	CNAs & Orderlies	54,509	55,506	578,229	10.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,088	10,552	112,560	10.67	10
11	Social Service Workers	1,805	1,896	17,070	9.00	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	42,644	20.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,968	17,583	164,709	9.37	15
16	Dishwashers					16
17	Maintenance Workers	4,310	4,457	47,346	10.62	17
18	Housekeepers	13,863	14,578	137,369	9.42	18
19	Laundry	6,992	7,494	66,415	8.86	19
20	Administrator	2,056	2,080	87,711	42.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,855	7,297	117,531	16.11	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)	141,861	147,022	$ 1,928,771 *	$ 13.12	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	$ 4,487	L1, C3	35
36	Medical Director	Monthly	8,350	L9, C3	36
37	Medical Records Consultant	Monthly	996	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,490	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	275	L39, 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)		$ 21,598		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dana Payton	Administrator	0	$ 87,711
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,711

B. Administrative - Other

Description	Amount
Moshe Herman / Momentum Healthcare, LLC	$ 120,000
SW Financial Services Fees (Eliminated on Sch. V, Col. 7)	64,509
TOTAL (agree to Schedule V, line 17, col. 3)	$ 184,509
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alan H. Cooper	Legal	$ 75
Ogle. Co. Recorder	Legal	42
HK Payroll Services Co.	Accounting	250
McGladrey LLP	Accounting	23,506
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 23,873

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,446
Unemployment Compensation Insurance	69,407
FICA Taxes	148,746
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	9,143
Holiday Expense	116
TOTAL (agree to Schedule V, line 22, col.8)	$ 268,858

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,486
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,245
(Indicate # of checks performed 103.8)	
Patient Background Checks	
Illinois Council on Long Term Care	9,307
Miscellaneous Dues & Permits	95
Miscellaneous Inspections & Licenses	985
Allocated from Management Co.	163
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,281

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,585
Allocated from Management Co.	70
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,655

**See instructions.

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XIX. Support Schedule
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	23,873
Allocated from Real Estate Entity- Accounting	2,110
Allocated from Management Company-Accounting	729
Allocated from Management Company-Legal	98
Total Allocated from Management Company	827
Allocated from SFO Associates-Accounting	3,322
Total (Agree to Schedule V, Line 19, Column8)	30,132

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

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

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-$9,307**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,040** 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. $ **199,620**
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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.